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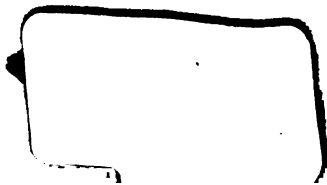
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1957

AUSTRALASIAN MEDICAL GAZETTE.

ORIGINAL ARTICLES

VON VOLKMANN'S METHOD FOR ECCHINOCOCCUS OF LIVER.

By J. B. ROSS, M.D., MACARTHUR, VICTORIA.

BEFORE Lister revolutionized surgery, all operations which involved opening of the abdominal cavity were regarded as being attended with great risk, and frequently terminated fatally.

In what dread abdominal surgery was held is evident by Von Swieten's remarks upon J. L. Petit's advice to operate for gall stones as well as for stone in the bladder. *Porte prima fronte audax apparebit facinus talia moliri, sed certe audacior ille fuit, qui primus ex vesica urinaria sectione calculum educere tentavit.*

The end and aim of all methods for operation of echinococcus of liver were to avoid the escape of the fluid into the peritoneal cavity. For this purpose Moissenet recommended capillary trochar, but he had to complain of a death a few hours after a preliminary puncture. This fact induces Trousseau to warn his readers to be careful and cautious in informing, even before a preliminary puncture, the patient and relations that death has taken place under circumstances where there seemed to be nothing to account for it. By using the capillary trochar the mother cyst remained and gave frequent trouble, which led Jubert de Lambelle to use a big trochar. But here the danger of the fluid escaping is still greater, therefore the author recommends the canula to be left in the wound for twenty-four hours. Bégin's advice is to cut successively and carefully down to the peritoneum, plug the wound and incise forty-eight hours after. Recamier used caustics; Trousseau inserted from thirty to forty needles through abdominal walls into cyst, left them there for three or four days, and repeated it twice. Hiesberg advised multiple punctures, whereas Simon recommended double puncture, to be followed by incision. Many other modifications have been published, but all were unsatisfactory. The antiseptic wave swept all those operations away. Reliance upon aseptic operations, and the conviction that such was attainable, gave the knife into the hand of the surgeons, hence the two operative methods—Lindemann and Von Volkmann.

Davies-Thomas, Gardiner and Verco have, both by word and letter, brought Lindemann's operation pre-eminent before the confrères for imitation, and have substantiated their recommendations

by splendid and admirable results. But for all that they have not found many followers in this colony. The reason is, I think, that surgeons have not sufficient confidence in the antiseptic measures they take. The general practitioner is, as a rule, devoid of that operative dexterity absolutely necessary for such operations. Want of skilled assistance is another factor which weighs heavily against the general adoption of Lindemann's method.

The intention of these notes is to prove that Von Volkmann's method is just adapted for the universal use of the general practitioner who is called upon to operate where skilled assistance is not available.

Before I relate my two cases where this operation was employed, I will lay down my antiseptic measures, as I think that strict attention to them is a guarantee that success will ensue.

Although I was called upon to operate in one case of double hydatids under most unfavourable circumstances (there being eight persons to the family and only two rooms in the house), I am pleased to say the temperature never rose above 99½ Fah., and even this rise was easily accounted for apart from the operation. There was no reaction in either case.

In the case mentioned above the patient, a little boy, was unaware of any wound until, in an unwatched moment, he slipped his hand under the dressing and felt the holes.

My antiseptic precautions are as follows: On the day of operation the patient is ordered a warm bath; the room cleared of all unnecessary furniture, especially all hangings are removed, floor scrubbed, bedstead washed, clean sheets, etc., put on the bed, and clean clothes on the patient. All the instruments are boiled for fifteen minutes and then put at once into 5% carbolic-acid lotion. The region of operation is shaved and then brushed and washed with warm water and soap, and finally thoroughly washed with 5% carbolic-acid lotion.

Professor Nussbaum, of Munich, informed me in a letter that he washes and brushes twice with hot water and potash soap, then washes with sulphuric ether, which is followed by a 5% carbolic acid or 1% corrosive sublimate lotion. He asserts he is very successful.

Of equal importance is a thorough disinfection of the surgeon in order to guard against contact infection. Here I cannot help expressing my astonishment at what some consider disinfection of self. Washing the soiled hands for a moment in 5% carbolic-acid solution, and then operating. When bad results supervene they are put down

to some complication or other independent of the operation.

By a series of experiments inaugurated by Kümmler, and prosecuted by Führbringer and others, it has been conclusively proved that the hands, especially the so-called subunguale-room (space between the nails and pulp of fingers) is exceedingly apt to infect wounds.

For a thorough disinfection of hands Führbringer demands that—

- I. The nails be cleaned of visible dirt by some dry means.
- II. To carefully brush hands, especially subunguale space, for one minute in hot water and soap, followed by
- III. Washing in alcohol of not more than 80° for one minute, and then, before they get dry, put into 8° carbolic-acid lotion or 2-2½% corrosive sublimate lotion for another minute.

This plan has been followed with marked success, and is well borne by the hands.

In all ordinary cases (except of course where the surgeon has been operating on abscess or similar affections) I think five minutes good washing and brushing with hot water and soap, and one minute's washing afterwards in either of the antiseptics mentioned, will suffice.

The arms are disinfected as well, and kept uncovered unless especial garments are worn.

Another source of great danger to the patient is the use of sponges. A thorough disinfection of soiled sponges is absolutely necessary before using them again. I refrain from giving the details of a proper disinfection of them, as I consider it best to dispense with them altogether. I use instead balls of absorbent cotton wool, well sterilized, which are placed in square pieces of absorbent gauze about the size of the palm of the hand, the corners of which are twisted together. As soon as used they are thrown aside. Following the suggestion of Von Volkmann, I used cocaine in one case with splendid success. Half a grain was injected, two injections being made. Complete anaesthesia of region of operation followed.

The use of cocaine, where applicable, will enable the practitioner to dispense with any skilled assistance whatever, although, bearing in mind the tragic end of the eminent Russian surgeon, M. Kolomin, the presence of another medical man is desirable. I have successfully employed cocaine without any bad effects, but, although I have been in the strange situation of asking a patient to hold this and that while removing a tumour from his neck, I am not so sanguine as to see in it a panacea for all and every operation to be performed with the sole assistance of the patient himself.

I have only two cases to report upon, but thought it well to bring them before the profession and ask my confrères to adopt Von Volkmann's method for the removal of hydatid cyst, on account of its safety and efficiency.

My first patient was Mr. McB., State school teacher in O. When I first saw him the history of his sickness pointed to pneumonia, but examination of chest failed to detect the physical indications of the complaint. I found a probable enlargement of liver. Patient was of delicate build, little panniculus, muscles wasted; temperature, 99½ Fah.

I thought it was diaphragmitis, attended with deep-seated pneumonic infiltration, just about to terminate critically. Besides that probably first stage of cirrhosis of liver as well.

A week later I was again called in. Setting aside my former diagnosis I concentrated my examination to the left lobe of liver. A preliminary puncture yielded pus.

On microscopical examination I found more red blood corpuscle than I could account for by piercing the abdominal walls, and came to the conclusion that the cyst was below substance of liver. This proved correct by operation. I placed the different methods of dealing with hydatids before the patient, who decided at once for radical operation.

In this case I used cocaine. Half a grain was injected hypodermically by Dr. Scott, of Warrnambool, who assisted me. The operation was perfectly painless, the bleeding very little.

After cutting down to the peritoneum I carefully assured myself, by means of the previously mentioned plugs, that all bleeding had stopped.

A small hole was made in the peritoneum, the director introduced and guided by it, the peritoneum was cut open with probe-pointed scissors. (Von Volkmann makes the incision about 10 ctm. long through abdominal walls.)

The liver presented, as anticipated, no adhesions being found. Iodoformed gauze was then plugged between liver and abdominal parietes, the wound itself plugged with the same material. Above this salicyl cotton wool was placed, and over that again carbolized jute. A gauze bandage covered the whole.

From that time until seven days later, when the cyst was opened, there was no reaction whatever.

On the seventh day, without the aid of any anaesthetics, I cut, with a Paquelin, through about 1½ inches of liver, protecting the adjoining tissue from the radiating heat by means of wadding plugs. After opening the cyst and evacuating the purulent contents, I tried to separate the mother cyst from the fibrous capsule, but was obliged to desist,

after succeeding to some extent, on account of the patient complaining of peculiar sensations.

I was afraid hæmorrhage would set in, which would have been difficult to stop.

The incision was made about an inch below the margin of the ribs, a little to the right of linea-alba, parallel to the ribs. On introducing my index I felt the cyst extending so far to the right that I was unable to reach the extremity. In the front I found it adjoining the thorax. In other directions bounded by liver.

The following day I made another unsuccessful attempt to remove mother cyst. The cavity was washed out every day by means of a glass syringe, to the nozzle of which an india-rubber tube was fixed. Once only had I to resort to a weak solution of permanganate of potassium as the contents evinced a bad smell, otherwise pure water was used. Patient was out of bed on the eighth day after the cyst was opened, sitting up greatly facilitating escape of discharge. No bile appeared during whole period of recovery. The only incident worth mentioning is that the patient complained of what he called emissions of semen.

After a lapse of three months the drainage tube was removed. At that time I was informed there was no discharge, and the fistula was filling up. A few days later the wound closed altogether.

The following case is of greater interest.

A little boy, nine years old, of very delicate health, was brought to me on account of his big belly. His appetite was failing, and he screamed out during the night. Heavy perspirations, which for years formed a prominent feature in the previous case, were not complained of here.

On examination of patient I found dulness of liver reaching to about $1\frac{1}{2}$ inches below margin of ribs. A preliminary puncture made in an upward and inward direction from a point about two inches from linea-alba, and as far from margin of ribs, yielded clear fluid, not coagulating on heating. Microscopical examination was of no diagnostic value. About eight days later the boy was brought to me again, and I then found a prominent tumour just escaping from under the left rib. This tumour was distinctly separated from dulness to the right side of processes Xiphoides by a tympanitic zone. A preliminary puncture yielded slightly opaque fluid not coagulating on heating. Microscopical examination revealed abundance of leucocytes. This puncture was followed by abdominal pains, but no rash appeared. On account of this fact and abundance of leucocytes I inclined to radical operation, to which the parents readily consented.

On seeing the patient ten days later I found the left prominence further down and separated from the margin of left ribs by a tympanitic zone.

I thought I had to deal with a cyst free in the abdomen. Dr. Bennett, of Hamilton, who assisted me, administered chloroform, as we thought it necessary to dispense with cocaine on account of the excitable nature of the boy. I performed Von Volkmann's operation on two places at the same time, the plan of operation and dressing being the same as in the previous case.

On the left side the cyst presented, on the right, the liver. To avoid the prolapse of intestines after opening of peritoneum, I made the incision a little above the zone of absolute dulness.

There was no rise of temperature above $99\frac{1}{2}$ Fah., although the patient caught cold during operation; there being no fireplace in the room he occupied. A few days later diarrhoea set in. For these reasons I postponed the opening of both cysts till the eleventh day. Judging by my preliminary puncture, I expected to find the right cyst immediately under the surface of liver, a careful palpation of exposed liver being thought unnecessary. Had I seen Dr. Graham's paper, (*A. M. Gazette*, July 15th, 1889, page 261), I would not have relied on my puncture, which was made with a small, short Pravaz syringe. In the paper alluded to Dr. Graham mentions that fluid almost identical with that of hydatid can be obtained in cases of ascites in hydraemic patients with waxy disease of liver, and even form a parovarian cyst. These observations call for the greatest discretion when dealing with fluid yielded by preliminary puncture. A careful and repeated examination would, perhaps, in my case have cleared up the situation.

For the reason mentioned above I felt sure I had only to cut through a thin layer of liver, and thought, therefore, I could dispense with chloroform. On account of size of cyst I considered it advisable to empty contents by trochar, so as to allow time for the circulation of the intestinal vessels to adjust themselves to the changing conditions. A trochar was inserted in exactly the opposite direction of preliminary puncture, the incision being made about half an inch above the place where the former was made. To my astonishment I had to force the trochar deep into the liver, and found, to my utter amazement, clear blood on respiration. I again tried, under the impression of having tapped a large blood vessel, but with same result; therefore I desisted.

[I may here mention that a few days previously the boy, in a state of alarm, called his mother into the room and told her something had burst in his belly.]

The boy was so excited by this time that even the sight of the knife made him unmanageable, so I used the trochar to evacuate the left cyst. The wounds were dressed with carbolicized jute.

All went well until the third night, when temperature rose to 108° Fah.

On the following day the boy was put under chloroform, when I made another preliminary puncture on the right side in the same direction as before, which again yielded clear blood. I now came to the conclusion that the cyst was on convexity of liver. On inserting trochar in that direction I found clear fluid. A canal was cut through whole depth of liver with Paquelin.

I leave it to the more expert to decide what I tapped previously while puncturing.

After all the fluid had escaped an attempt was made to open the left cyst. To reassure myself of presence of fluid I used a small trochar. I forced it downwards until I found it landing into a cavity. At the same moment the boy vomited, or rather retched, no fluid escaping from trochar. I tried again in different directions with the same result. This convinced me that I had punctured the stomach; I therefore left off. From this day temperature kept up between 100° and 102° Fah. The right cyst was washed out twice a day by means of an irrigator; the rest aspired by syringe. About the seventh day I succeeded in removing part of the mother cyst.

During this time an incident took place worth mentioning. Patient would wake, after apparently sound sleep during fore part of night, with severe pains and coldness in the right arm and down the right side of chest. He would continually ask his father to move his arm. This lasted each time for several hours, until the mother succeeded, by means of hot flannel, in restoring warmth to the arm. The boy would then fall asleep again, but complain of headache the next morning.

A few days later I again put patient under chloroform, and succeeded in opening the left cyst, which was partly filled with purulent fluid.

The following morning I was fortunate enough to remove a mother cyst, nearly cut in two; and also a smaller one, whole, but collapsed.

Shortly after the removal of the left cysts, the cavity being washed out twice a day, similar incidents as before mentioned took place, but this time in both legs. There was a clear interval between the former and latter attacks; epistaxis being observed during the time they occurred. A snoring noise, over which the patient had no control, was also noticeable at the same time. I will revert to these phenomena later on.

Although antiseptic dressing was used the discharge of right cyst soon became offensive, owing, I think, to its enormous size.

When I first saw patient, as well as on several subsequent occasions, I tried to palpate the liver, but failed each time, owing to the extensive tympanitis. After the evacuation of the cysts I

found the sharp edge of liver about an inch below umbilicus. It was easily and distinctly felt.

I was afraid to use any of the common antiseptic fluids in order to render the discharge aseptic, and decided, therefore, the patient being weak, to use alcohol, respect. whisky, anticipating a double result, viz. :—

I. Checking decomposition and facilitating separation of mother cyst by its contraction.

II. Sustaining the patient by absorption.

Of the latter I am not quite sure for, although I filled the cysts with about an ounce, no signs of intoxication appeared. This, of course, could be explained by part only being absorbed, and that very slowly. Be it as it may, the result was very striking; a few days later the smell disappearing and the temperature being 98° in the morning and between 99° and 100° at night. It continued varying between those degrees for some time. The patient was out of bed for three hours or more every day; his appetite improved, he got cheerful and lively, when suddenly the temperature rose to 104½° Fah. The abdomen was swollen, tenderness in the hyponchondria, especially in the right side. There was also a recurrence of pain and coldness in the right side and arm on two occasions, lasting only about half an hour, but not so severe as before.

As there was no offensive discharge from either side I arrived at the conclusion that a remaining and unopened cyst had become purulent. After a careful examination I made thoracocentesis in the right axillar line in the eighth intercostal space and found the cyst containing pus. This abscess had no communication whatever with the cyst previously opened.

A few days after the last operation I again noticed a rise of temperature with an offensive discharge from the first-opened cyst.

The escape of bile through the fistula, which had been moderate, now became more abundant.

I may mention here that the stools were always a physiological colour according to the diet, and were never clay-coloured.

I now fixed a rather large, but pliable, india-rubber tube to the glass syringe and forcibly injected a permanganate of potassium lotion into the cyst. On two successive mornings I succeeded in removing an enormous quantity of pieces of mother-cyst and also daughter-cyst. After this the temperature fell to about normal. The appetite, which had been poor, returned; patient slept better, and a marked improvement took place. Two months after the preliminary operation the cavity on left side is almost closed; the abscess on right tends to contract, discharging little, but there is copious secretion of pus from

cavity of the middle cysts. To check this I employed perfusion with disinfected air, as recommended by Roser for empyema, and latterly successfully tested by Dr. W. Ewart in a case of empyema, with pulmonary gangrene.

The patient is almost free from fever, the temperature sometimes reaching $100\frac{1}{2}^{\circ}$ Fah., and this only after the usual sleep after dinner. With this exception the temperature is normal.

About two years ago I treated Miss McG. for meta-pneumonic empyema. As soon as diagnosis was established I tapped, but this being insufficient, thorococentesis, with excision of part of rib, was resorted to. I ordered cavity to be washed out with a lotion composed of one teaspoonful of iodine tincture to a pint of water. After about an ounce of fluid had been injected for the first time, the patient experienced a stiffness in shoulder of affected side, which was followed by coldness and deadly paleness of skin, the whole gradually spreading down from the centre to the periphery, even the nails of the fingers being white. The pulse on the right side stopped beating for several seconds, but was easily felt on the left. There was free movement of the arms and fingers. The sensation of stiffness was felt all over the right side and down to the thighs. As warmth returned the skin got redder than usual, the face, and especially the paraspinal of the right ear, being marked for their scarlet colour. Redness and warmth set in in the same order as the former phenomena had appeared, i.e., from shoulder to fingers. The line of progressing red zone was sharply defined and oblique, which latter was especially noticeable on the finger. The little finger got red first, and the index the last. While warmth was returning patient felt a sensation as of pins and needles. The same phenomena, though not so severe, occurred again the next night while dressing. The following night only sickness was complained of. After this there was no recurrence of phenomena.

A few days after incision of right cyst similar phenomena were noticed in the little boy. As they occurred during the night the only information I received was that the pain was very severe and lasted for several hours. The arm was pale and icy cold, and the mother instinctively put hot flannels to it. With returning warmth the pain and stiffness disappeared. Fingers and arm could be moved freely. Here, too, the sensations were felt down the right side. I first thought that the thick, hard Nélaton had caused this, therefore I replaced it by a soft tube, but the same occurred for three nights.

I collected more information about the affection in the legs. Shortly after removal of the left cysts, coldness, stiffness and pain were complained

of in both legs. There was hyperæsthesia to such a degree that even the bed clothes were felt to be too heavy. The boy resented any examination, sometimes refusing to allow the blankets to be removed, or his mother to touch his legs. Once she noticed the skin resembled goose-skin. On every occasion when possible to ascertain it was cold to touch and deadly white. Twice he complained of sensation of pins and needles. Here also hot flannels were resorted to. After a varied period of half an hour or more warmth would return and the boy fall asleep. On awaking he complained of headache, the temperature being higher than before attack. On examination afterwards I found hyperæsthesia along course of nervous cruralis. During attack the movements of legs were not interfered with.

Although I have no detailed particulars I think I am justified in assuming the course of events was the same as in Miss McG.'s case, at any rate the subjective phenomena were exactly similar. Whether the application of hot flannels had any therapeutical effect I am unable to decide; it appeared, however, to have a palliative effect upon the boy, which was of great value on account of his excitable disposition.

Raynaud calls vasomotor spasm of extremities "local asphyxia," and remarks that patients refer to it as coldness and deadness. The disease called after his name is chiefly characterized by the symptoms mentioned and symmetrical gangrene, the latter of which need not always be present.

In the *Glasgow Medical Journal*, 1888, vol. xii., page 425, Dr. Tannahil reported a case of a girl, æt. 7 a., where in the space of five years twenty attacks were observed, one only terminating with superficial gangrene of two toes, in all the other ones *restitutio ad integrum* ensued.

As cases of Raynaud's disease are not frequently observed I think every observation that could throw light on its causation is worth a notice.

The phenomena which I have just related have much in common with those of Raynaud's disease, and, as some explanation of their occurrence is found here, I give them in detail.

In Miss McG.'s case the cause was local irritation of the vasoconstrictors. The vasomotor nerves enter by way of nervus sympathicus the ganglion thoracicum suprenum and from there through the nervi communicantes the plexus brachialis.

As the phenomena occurred immediately after injection there is every reason to assume that the additional fluid increased the pressure within and irritated the ganglion thoracicum.

As the cause was unilateral the effect was the same. The short duration of cause prevented local asphyxia terminating with gangrene, but there is no doubt that it would have ended so had the pressure lasted longer and the nervous elements been unable to adjust themselves to the changed condition.

The phenomena of the little boy are more difficult to explain, but they are directly or indirectly dependent upon the incision of the respective cysts.

Moreover the recurrence of them in the arm, and also in connection with other indications, led to a thorough re-examination of same side with the result of finding another cyst, the opening of which was followed by a cessation of symptoms.

After incision of right cyst great discharge took place, which had sometimes free escape through canula, and at others was kept back by pieces of mother cyst blocking it. As the latter was situated on convexity of liver the diaphragm would be forced upwards whenever canula was blocked until it reacted by contraction. The liver was prevented by adhesions from moving in any direction. The thorax acting as an unyielding wall the tension would be sufficient at times to cause irritation of sympathicus. By irradiation the ganglion thoracicum would be involved, and result in phenomena recorded, viz.: coldness, paleness, and pain in arm and side.

More difficult still is the explanation of causation of asphyxia in both legs.

I am unable to give in detail the position of left cysts, a digital exploration being impracticable. But I may fairly assume that they were situated on upper aspect of left lobe of liver, overlapping the stomach. The cause of asphyxia in both legs must be a mechanical and local one, but how it acted I will not venture to explain, as I think the above theories are too open to discussion.

Nearly all writers on Raynaud's disease remark the frequent occurrence of hæmorrhages, such as profuse menses, epistaxis, hæmaturia.

In the case of the little boy epistaxis frequently occurred during the time the phenomena were observed, which fact points to a still closer relation to Raynaud's disease.

In conclusion, I may be permitted to make a few remarks respecting the death rate of Von Volkmann's and Lindemann's methods.

J. D. Thomas collected twenty-one cases operated upon by different methods in two or more stages, exclusive of Lindemann's.

The death rate was 19,058, namely, 4 deaths against 17 recoveries.

It is not fair, in my opinion, to collect for statistical purposes operations performed before as well as after antiseptic era. These might be com-

pared against each other as to their respective merits, but not in the manner Mr. Thomas employs them.

Moreover it is incorrect to compare the results of operations performed after different methods with the results of one particular one.

I will give a striking example:—

	Cases.	Deaths.	Death rate.
Method A ...	10	0	0%
„ B ...	10	2	20%
„ C ...	10	3	30%

A + B + C = 30 cases, 5 deaths; death rate, 16.6%.

Taking now the resulting death rate 16.6% of the 30 operations and compare with it method D—30 cases, 4 deaths; death rate, 13.3%; and to conclude method D is superior to the above-mentioned methods is an error in *ratione*.

Method D is perhaps superior to method B as well as C, but inferior to A, each of which has to be proved by an equally long list of operations.

Lawson Tait, *Lancet*, June 29th, 1889, page 1294, on commenting upon a statistical paper compiled by Dr. A. Depage to contrast the operation of cholecystotomy with that of cholecystectomy remarks: "It must be clearly understood that there is a great difference between the mortality of a large number of operations collected from the work of operators who have done one or more operations each and a collection of operations done by one particular surgeon, or by two or three selected on account of their experience. *These latter will give the mortality of the operation*, whilst the other method will give the mortality of a bundle of individual and mostly inexperienced operators."

Further comment is unnecessary.

Krause, *Klinische Vorträge*, No. 325, records twelve cases of hydatid operated upon by Von Volkmann with one death only. Patient died seventeen days p.o. from uræmia supervening chronic nephritis. This death is not in the least degree attributable to the operation, which is said to have been successfully performed.

Death from exhaustion by copious secretion of pus might take place of any method, the method itself is not to blame for that.

Kamla gives a statistic where Lindemann's method figures with 6% death rate, and Von Volkmann's 0%.

Mr. Thomas's collection of Lindemann's yielded a death rate of 10.29%. For an explanation of the vast difference in the result arrived at I need only refer to the quoted remarks of Lawson Tait.

In the same paper, *Australian Medical Journal*, June 15th, 1889, page 246, Dr. Thomas says: "This operation is decidedly inferior to that of

Lindemann's, which is next described, and presents no advantages as to safety."

If by "this operation" Von Volkmann's is meant, the statement is incorrect.

As regards safety Von Volkmann's method is superior to Lindemann's, and it has the same advantages as the latter.

The success of Lindemann's operation depends upon careful stitching of the cyst to the parietal walls, and prevention of escape of any fluid into the peritoneal cavity. It is well understood this is not easy to attain, even with a sufficient number of skilled assistants. Where no skilled assistance is to be had it is almost out of the question.

To employ Lindemann's method successfully surgical skill and experience, also skilled assistants are indispensable, each a *conditio sine qua non*, and as those cannot be expected from every general practitioner, it has not found favour with them, but has been the domain of a select few only.

On the other hand, Von Volkmann's operation can be performed by every one sufficiently familiar with the common surgical manipulations.

The administration of cocaine, where applicable, enables the surgeon to dispense altogether with skilled assistance, although it is desirable.

I performed all subsequent operations with lay assistance, Mr. D. E. Williams, of this town, efficiently rendering all necessary help.

Where there is no imminent danger of the cyst rupturing I do not see what harm can accrue to a patient from a delay of a few days, especially as this delay spares him a great risk and does not interfere in the least with his ultimate convalescence.

After opening of cyst the chances of recovery after Von Volkmann's method are exactly the same as after a successfully-performed Lindemann's.

One might object that even after a lapse of ten days adhesions are not sure to be found. Should there be any fear in this direction, stitching the cyst to the abdominal walls can be resorted to.

Another objection still to Von Volkmann's operation may be raised, that of overlooking the presence of another cyst, but the incision being ten ctm. long, the surgeon will be enabled to avoid this by a careful palpation of exposed liver.

Krause, in concluding his paper, recommends Von Volkmann's method in cases where the cyst is suppurated and no adhesions are formed, and in those where a cyst has ruptured into a bronchus or intestine.

P.S.—Since the above was sent to print, I had again occasion to adopt V. Volkmann's method.

Mrs. W., æt. 35, came to consult me about numbness and deadness of right arm, inability to sew, sleeplessness, loss of appetite, &c. A careful examination revealed an hydatid cyst occupying the front of right chest bounded to the left by mediastinum, reaching upward to the fifth rib, to the right, to about an inch outwards of mamillar line. Sharp margin of liver from umbilicus to short ribs.

While Dr. Baird of Belfast administered chloroform I made incision along conjoint cartilages of seventh and eighth ribs; excision of part of those; incision of Diaphragma. In this case I pushed the gauze far back between cyst and chest walls.

As the preliminary puncture was made immediately before the operation on loco-electionis the high tension of cyst caused an oozing of fluid sufficient to wet the bandages right through.

I mention this fact as a warning for those cases where the contents are purulent. No reaction followed; temperature never registering above 99° Fahr; week later opening of cyst; circumstances prohibited immediate removal of mother-cyst which is coming away in more or less large pieces. The patient is reported as making a very favourable recovery, special mention being made of her being able to sew.

To give an instance of the rapid growth of hydatids I might mention an instance that came under my notice lately.

A father brought me his son three-and-a-half years old, with a tumour on the right groin. About thirteen months ago the father says this tumour was about the size of No. 1 shot. Four months ago I found it as big as a hazel nut. Since then it grew rapidly, and on removal was the size of a walnut as above stated. The tumour proved to be an hydatid cyst which was easily extirpated.

ON THE TREATMENT OF IN-GROWING TOENAIL.

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Fig. 1.—In-growing Toenail.

THE ordinary treatment of in-growing toenail, if we may judge by the letters which appear on the subject, from time to time, in the columns of the various medical journals, and by the number of cases one too often sees returning after operation with a regularity alike disheartening to

the sufferer and disappointing to the surgeon, is not altogether an unqualified success.

Only those who have experienced it can understand the amount of agony this apparently trivial affection entails on the unfortunate possessor, and the gratitude with which relief is hailed.

Treatment usually resolves itself into one or other of the following methods:—The application of caustics; packing with pledgets of wool; scraping with glass in such a manner as to develop a median groove along the nail; and, for the more severe cases, avulsion, partial or complete, of the offending unguis. These are all more or less palliative. Removal of the nail is a barbarous proceeding, is very seldom curative, and has, at least in one instance related by Erichsen, been followed by gangrene of the foot, necessitating amputation, so that it is a procedure not altogether unattended with danger. In many cases, too, the operation has to be repeated owing to injury of the matrix. A really good plan, and a decided advance on those enumerated, is that of H. T. Masters, as given in Pye's *Surgical Handicraft*. It cannot, however, be adopted in every case. It consists of a silver lever made out of a threepenny bit filed on the flat; this is fashioned somewhat in the shape of the letter S; one end is placed under the nail in such position that the concavity fits over the granulations, exerting pressure on them and lifting up the buried border of the nail from the sensitive parts below when pressure is applied by a bit of plaster wound round the toe; in other words, the granulations act the part of fulcrum to a lever of the first order, the power being applied by the strapping.

I shall now briefly describe a method devised by myself, and which has, in every case tried, given me good results. As in Masters' plan, the atrophic effects of constant pressure are brought into play, but the application is somewhat different. The materials which are always available are the following:—(1) Metal capsule from a champagne bottle; (2) Medium-sized vial cork; (3) Sharp pen-knife; (4) Strip of plaster. As a preliminary, the patient's foot is prepared by a thorough washing in a solution of Condy's fluid or boric acid, and afterwards carefully dried with a soft towel. Finely-powdered iodoform is then dusted over the painful granulations and under the free border of the nail by means of a camel's hair brush. The iodoform, in addition to being an antiseptic, in virtue of the free iodine given off in the presence of pus, possesses also a certain amount of anæsthetic action, and is consequently very suitable in such cases, the only drawback being its most offensive smell, which some patients absolutely refuse to tolerate. Now,

from the metal capsule, previously rolled into a sheet, cut a strip somewhat resembling a capital U with closely approximated and elongated limbs; roll one of the limbs upon itself

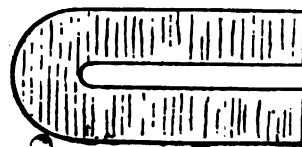


Fig. 2.—"Protector."

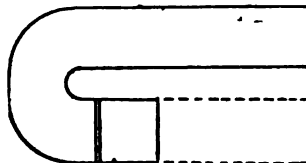


Fig. 3.—Limb rolled upon itself to be inserted under free edge of nail.

christened the "protector." Fig. 4 gives a diagrammatic representation of this stage.

Another flat strip of metal is now cut and shaped with the fingers, like a capital V, both limbs having a concavity looking downward with the right-hand limb very much longer than the left.

and insert under the free edge of the nail. A little practice will determine the requisite length of this portion of the apparatus which I have

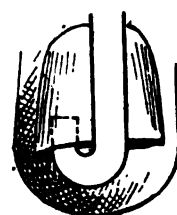


Fig. 4.—"Protector" in position.

This I call the "shield." The granulations are now to be separated from the nail, and the apex or wedge of the "shield" inserted between. A wedge-shaped segment is cut from the cork, the base being convex, the sides concave. This is placed between the limbs of the shield, and the whole completed by a strip of Mead's adhesive plaster wound round the toe from above, downward. It is as well to turn the limb of the "protector" running up the dorsum of the nail down over the plaster in order to prevent shifting. The advantages I claim for this method are:—

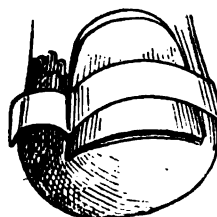


Fig. 5.—"Shield" in position. N.B.—For sake of clearness, "Protector" previously applied is not shown in the diagram.



Fig. 6.—Cork wedge to fit over shield as in Fig. 7.

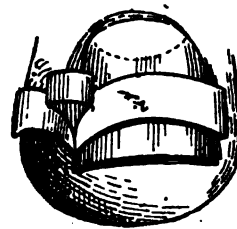


Fig. 7.

1. Facility and painlessness of application.
2. It is suitable for almost every case.

3. The dressings may be left undisturbed for weeks at a time, with positive benefit in many cases.

4. It is effective.

Those of my professional brethren who may give this method a fair trial will, I am sure, feel satisfied with the results obtained.

CASE OF PITYRIASIS RUBRA*—CURE.

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F.R.C.S. IREL., SURGEON TO THE DEPARTMENT FOR DISEASES OF THE SKIN, ALFRED HOSPITAL, MELBOURNE.

THIS affection was pronounced by V. Hebra to be incurable. Kaposi, however, has reported a case which he cured, and also one narrated to him by a colleague, who cured himself, he being the sufferer. The authority of Kaposi is hardly second to that of V. Hebra, whose classical description of this most terrible affliction is the criterion by which all cases of this kind must be judged. To justify the diagnosis of pityriasis rubra, therefore, a case must present the following characteristics according to Von Hebra:—"During the whole course of the affection it must be accompanied by no other appearance except that of a persistent intensely red coloration of the skin, without considerable infiltration, formation of projections or pustules and development of sulci or moisture, which is combined with a varying amount of itching, and is seldom localised, but usually selects the whole cutaneous surface of the body for its habitat. You can drive out the redness by digital pressure, which leaves a yellowish colouring of the skin in its place. The skin itself sometimes shews, in places where the scales are wanting, a peculiar red, glazed and shining appearance through which can be seen the deeper jelly-like structures of the skin." In my case about to be narrated the latter condition was peculiarly well-marked over the whole of the face, notably the forehead, and helped to clinch the diagnosis otherwise rather difficult, although the scales and their size and number would alone almost be sufficient to establish the case. It was at times nothing to collect a ward basin full of scales up to the size of half-a-crown out of the unfortunate man's bed in the morning, and the tension of the skin of the face would almost tempt a surgeon to give relief by incision. My case therefore is indisputably one of pityriasis rubra, which had been under treatment by a great number of medical men, as well as at the Mel-

bourne Hospital, where there are no beds for this class of cases, and was referred to me by Dr. Peipers; it corresponds in every particular to the description of Von Hebra save one, and that (its incurability), I am happy to say, is an unsettled point. I believe the whole of the staff of the Alfred Hospital has seen this remarkable and interesting case, and certainly every visitor has been shown it from time to time, yet I am unaware that the diagnosis has ever been or is likely ever to be disputed. It remains therefore the only case of the kind ever cured in the Southern Hemisphere, and the only second reported in the whole world, Kaposi's being the first. I am indebted to Dr. Anderson, the indefatigable resident surgeon, for the following notes of the case, and I take this opportunity of thanking him for the lively interest he displayed in the case, to which I must certainly attach a very considerable amount of the credit due for bringing it to a successful issue. The practitioner who calls no case a failure until it dies will often get surprising results by simple perseverance and adherence to general principles even in the most desperate cases; it certainly never entered our heads to discharge this poor man until something was done for him, and it is needless to add that the result exceeded our fondest imagination.

L.L., æt. 39, S., professor of music; admitted July 6th, 1888.

Patient complains of a scaly eruption of the skin, which has been present for four years.

It first appeared as a small red patch, about the size of the palm, on the front of the chest. This eruption was not raised, irritable, or tender; it spread very slowly on the chest, and at first there was no scaling.

About a fortnight afterwards patient noticed a similar patch on the left side of the forehead; and he then consulted a medical man, who gave him mercury, which salivated him and caused his teeth to become loose. The eruption continued to extend, and the skin began to exfoliate; he noticed also at this time that his hands and feet were swollen.

Two years ago the disease had extended so that the whole of the body and limbs was covered. The face (with the exception of the forehead) was not attacked till seven months ago. He noticed in January last that his eyes were getting painful and glued together, with discharge, in the morning when he awoke; shortly after, the rash made its appearance on the face, which was soon covered.

Since this time the eruption has varied in character as to intensity of colour, amount of scaling, &c., but has never left any part of the body.

Patient has noticed that his body is usually pale in the morning, but after his bath the skin becomes

* Synonym: General Exfoliating Dermatitis.

very red. The scales come off both by night and day, but mostly during the night.

Has some irritability of skin in the day time, but much more at night, so much that his sleep is greatly disturbed.

Skin is tender only after the bath and rubbing.

Patient has a great deal of conjunctival injection and profuse lachrymation. Eyelids are sometimes stuck together in the morning.

Patient's entire skin is of a deep red colour, the colour being less marked on the palms of the hands and soles of the feet. Redness disappears to a great extent on pressure, returning when the pressure is removed. Scales are present in large quantity, varying in size from a pea to a half-crown or larger. There is no exudation from the skin, and when the scales are rubbed off the skin is perfectly smooth.

Patient has considerable stiffness of the skin, especially about the joints, and feels rather weak in the legs if he walks far. Otherwise he enjoys fair health, and would be able to follow his occupation fairly well but for his appearance.

Appetite is good. Never vomits.

Tongue clean—not red.

Bowels regular.

Has no trouble with micturition.

Urine contains a large proportion of urates and a trace of albumen.

Patient had sores on the penis nine years ago—three in number—but had no bubo, sore throat, alopecia, or eruption. Has had similar sores twice since, eight years and nine months ago respectively.

Thoracic organs normal.

On admission the treatment ordered was as follows:—Patient to have a bran bath every morning, and then to rub himself with an ointment consisting of $\mathfrak{z}\text{ij}$ of ung. zinci, with $\mathfrak{z}\text{j}$ of lanoline. Equal parts of oxide of zinc and powdered starch to be used as a dusting powder at the flexures.

Internally a mixture containing sulphate of quinine and iron to be taken.

July 18th.—Very little alteration in appearance.

\mathcal{R} Liq. arsen. hydrochlor $\mathfrak{m}.\text{lxiv}$
 Acid mur. dil. ... $\mathfrak{m}.\text{lxxx}$
 Liq. saccharini ... $\mathfrak{z}\text{ii}$
 Vin ferri, ad ... $\mathfrak{z}\text{iv}$

M. Ft. mist, $\mathfrak{z}\text{j}$ 4ta horis, ex. aq. On the appearance of symptoms of arsenical poisoning the treatment was relaxed and altered as follows:—

August 22nd.—To take:

\mathcal{R} Hyd. iod. rub. ... $\text{gr. } \frac{1}{4}$
 Pot. iod. ... gr. viii
 Glyc. ... $\mathfrak{m}.\text{xxx}$
 Inf. cinch. ... $\mathfrak{z}\text{j}$ ad
 M. Ft. Haust ... tds.

To have after the bath: Ung. pot. iodidi c lanolino rubbed into the skin.

September 20th.—Patient's condition varies a great deal; sometimes he is almost natural in colour. Is always very red after the bath.

At present very few scales are coming off, and the skin is very light in colour.

\mathcal{R} Arsenici iod. ... $\text{gr. } \frac{1}{4}$
 Ext. nucis vom. ... $\text{gr. } \frac{1}{4}$
 Excipient ... q.s.
 M. Ft. pil. tds. p.c.

On October 10th he was put on 4 minims of liq. Donovan three times a-day—the dose to be gradually increased to 10 minims.

No appreciable improvement, however, seemed to follow, and on November 14th he was given the following mixture:—

\mathcal{R} Sodii bicarb. ... gr. x
 Tr. gent. co. ... $3\frac{1}{2}$
 Tr. podoph. ... $\mathfrak{m}.\text{v}$
 Succ. tarax ... $3\frac{1}{2}$
 Decoct. ejusdem ad ... $\mathfrak{z}\text{i}$
 tds.

This was taken till his discharge, the dose of the sodii bicarb. being gradually increased to gr. xxv .

Urine examined—no albumen to be detected.

On November 28th ointment of Chrysarobine (B.P.), diluted with lanoline, was ordered to be applied to the skin, and from this time an appreciable improvement was noticed.

At the end of December patient had to be removed to a tent in the ground, the ward in which he had been having been burnt. He was put in a small bell tent, the temperature in which at that time of the year was excessive, being over 100°F . for a great part of the day. However, patient's condition steadily improved, and he was discharged on January 27th, 1889, the scaling having quite ceased, and the colour of the skin being almost natural.

Patient has reported himself at the hospital several times since, and there has been no return of the disease.

August 29th, 1889.—Up to this date there has been no relapse. Mr. L. had lost all his pupils, and was reduced to poverty when he came into hospital, but is now enjoying a lucrative practice, being extremely well known in musical circles in Melbourne.

It is hardly necessary to add anything to Dr. Anderson's exhaustive notes except to point out that good doses of alkali, together with chrysophanic acid and lanoline (of which more anon) and bran baths, and, above all, persistence in whatever line of treatment is adopted, no matter how obstinate the case seems to be, will cure even pityriasis rubra.

201 Church-street, Richmond, Melbourne.

CASE OF DIPHTHERITIC PARALYSIS (?)

READ BEFORE THE N.S.W. BRANCH, B.M.A.

By GEO. E. RENNIE, M.R.C.S., ENG., M.D.,
LOND.

E. F. æt. 20, single, dressmaker, admitted to University College Hospital, London, on Jan. 9, 1888, complaining of loud gurgling noises in the abdomen when sitting up or moving about, which ceased when in the recumbent posture. She also complained of dull aching pains in the chest; not apparently worse after food. The noises were so loud that, without any exaggeration, they could be heard from one end of the ward to the other.

Previous History.—She had always been in fairly comfortable circumstances, a native of Elstow, in Bedfordshire, and had been a dressmaker for last five years.

Family History.—Father and mother both alive, fairly healthy. Three brothers living, one died from phthisis, another brother had hæmoptysis, with cough and wasting, probably phthisis, two uncles died of phthisis. Three sisters—one had Rh. F. and chorea. Patient herself had measles and Sc. F., also Rh. F. at 12 years of age; no chorea. Had had fairly good health up to about three months before onset of the present illness. At that time she visited a friend who was suffering from diphtheria, and afterwards had sore throat. On recovering from the sore throat she had some weakness in the legs and regurgitation of fluid through the nose. These symptoms, however, had all passed off about two months before the onset of the present trouble. There was no reason to suspect alcoholism or syphilis.

Present Illness.—In August, 1886, patient began to complain of pains in stomach, with gurgling noises, after her meals. These lasted about an hour and then passed off. The pains and noises seem to have got gradually worse, and she first consulted a doctor in January, 1887, and was treated by him for indigestion till April, 1887, but with no improvement. She was then admitted to the Bedford Infirmary, where she remained for four months. She was carefully dieted while there. Had some application painted on the abdomen, and electricity applied to the abdominal muscles, so far with no apparent benefit. She attended as out-patient at the Infirmary, and was again admitted there in November, 1887. She again had electricity applied to abdomen; also the stomach pump was used three times with still no improvement in her condition. She was sent up to London for admission to the Hospital as a case of "some obscure intestinal neurosis."

State on Admission.—Complains only of occasional aching pains in abdomen. Lies on her back or right side; when she lies on her left she has pain over cardiac region. Temp., 99°4. General nutrition good. No scars nor eruptions. Occasionally perspires at night; no clubbing of finger ends; no anasarca. Pulse, 104, fair strength, regular. Dyspnoea on exertion. Occasional palpitation. *Phys. Exam. of Heart.*—Slight precordial bulging. Impulse not visible. H.A.B. in fifth space $\frac{1}{2}$ inch inside upper line. Impulse rather diffused. No thrill. Heart sounds normal.

Nervous System.—Intelligence good. Sleeps well. Occasional headache. No rigidities nor convulsions. Giddiness at times. No spinal pain or tenderness. *Cranial Nerves* are normal. Pupils moderately dilated. Optic discs healthy.

Motion.—Movement of all the limbs normal in every respect. There is apparent inability to expand the chest except to a very small extent during forced inspiration. Sensation normal everywhere. *Sphincters* normal. All the reflexes, both deep and superficial, were present, and not exaggerated. I endeavoured to investigate the electrical reaction of the intercostal muscles, but found it impossible, as all the limb muscles attached to the chest responded well to the faradic current; but on application of the faradic current to the chest walls the ribs were elevated and the chest expanded.

Respiratory System.—Respirations 20. Dyspnoea on exertion. Slight pain in chest at times. No cough. No hæmoptysis.

Phys. Signs.—Skin of chest normal. Fair amount of fat. No localized depression nor flattening. During inspiration there is only slight expansion of chest at the lower part, and practically none at the upper part. There is some slight elevation of upper part of chest during inspiration, but not much. The diaphragm contracts vigorously during inspiration, and the anterior abdominal wall protrudes considerably more than natural.

Palpation confirms the above with respect to movements.

Vocal fremitus well marked everywhere. No Rhonchal nor friction fremitus.

Percussion.—Fair resonance on both sides of chest, both in front and behind.

Auscultation.—*In Front.*—*Right Side:* Inspiratory breath sound is jerky or wavy, but vesicular. Expiration rather harsh.

Left Side.—Breath sounds not so loud as on right side, but inspiration has the same wavy character, or, as it is sometimes called, "cog-wheel" type. On both sides the breath sounds are accompanied by peculiar churning noises conducted from the abdomen.

Behind.—Breath sounds are almost completely obscured by the loud churning noises, which can be well heard even at the apices, and appear to be immediately under the stethoscope in the chest, but are really only conducted. Breath sounds can be heard at times, and are apparently quite normal, with no adventitious sounds. Vocal resonance good everywhere.

Alimentary System.—Slight white fur on tongue. Appetite poor. Rather thirsty. Complaints of slight pain in left hypogastric region of a dull aching character; not worse after food. Nausea at times, but no vomiting. Bowels very constipated, sometimes going over ten days without relief except by medicine.

Phys. Exam. of Abdomen.—Abdomen somewhat distended. Becomes very prominent during inspiration. No tenderness on palpation; no tumour. Upper limit of liver dullness in nipple line was fourth intercostal space. Lower edge of liver felt at costal margin. Spleen not enlarged.

Urine.—Sp. gr., 1012 acid. Occasional deposit of urates. No albumen nor sugar.

Menstruation began at 16 years, regular every four weeks till first of present trouble. Since then almost every fortnight; sometimes excessive discharge. Generally suffers great pain at the time.

Progress of Case and Treatment.—Two days after admission she had a large enema of soap and water, castor oil and turpentine, and the bowels thoroughly cleaned out, and she was ordered some gentian and soda, with cajuput oil. She had an enema every third day. Still with no improvement. On Jan. 28 she was ordered sulphur baths thrice weekly, and the constant current down spine daily. She had various tonics, but the tongue still continued furred and appetite poor, and with absolutely no improvement. On March 28th she was ordered liquor arsenicalis, bromide of sodium, and inf. calumbæ. The arsenic was gradually increased. The faradic battery applied daily to both sides of chest. She was taught to exercise her arms, so as to assist in the expansion of the chest. The constipation was treated with pills of ext. aloes, bellad., and nux. vom. every night. This treatment was continued till end of April, with most decided improvement. The chest was expanded much better during inspiration, and the noises in the abdomen much less. The medicine was suspended for a time and again renewed. She left hospital May 25th, much improved, taking the pills every other night and the arsenical mixture. She reported herself again about the middle of June, perfectly well, looking quite healthy.

Comments.—This case, I believe, is almost unique, for none of the physicians who saw the

case had ever seen anything like it; and though I myself and others have searched through various books and periodicals we failed to find any similar case, and no positive diagnosis was arrived at. No doubt the patient suffered from dyspepsia and constipation; although borborygmi are common enough in patients suffering in that way, yet I have never heard of, nor seen a case in which the churning noises were so loud and rhythmical. Then there was the obvious inability to expand the chest, and the respiration was almost entirely abdominal. The question of the affection being possibly hysterical was discussed, but negatived, as there was not the slightest suspicion of hysteria about the patient, though she was carefully watched. Dr. Charlton Bastian, who was the physician in charge of the case, called it "Intestinal Chorea," and inclined to the view that it depended on some chronic disease—functional or organic—of the spinal cord. He compared it to disseminated sclerosis, in which disease, if the patient reclines, the tremors are almost absent, but if he sits up they become well marked, the difference depending on some special alteration in the condition of the spinal nerve centres, but I failed to see the analogy of the two cases; and the entire absence of any other symptoms of spinal disease, and the normal condition of the reflexes, seemed to me to negative such a view. In thinking over the case, the possibility of its being diphtheritic paralysis of the intercostal muscles crossed my mind, and it was then that I elicited the history of sore throats which were followed by what, I think, were undoubted symptoms of diphtheritic paralysis. These symptoms had disappeared completely some two months before the onset of the present trouble. A difficulty arises in connection with this view. Paralysis of the intercostals is usually regarded as one of the most dangerous of symptoms in diphtheritic paralysis. On this point Dr. Gowers says:—"The paralysis of the intercostals may interfere seriously with respiration, and unexpelled mucus may accumulate in the bronchial tubes and give rise to alarming paroxysms of dyspnoea, which in children are often excited by emotion. Duchenne asserts that the muscles of the bronchial tubes are paralysed in these cases, but the statement rests on inadequate evidence, since there is usually sufficient weakness of the thoracic muscles to explain the symptoms. When the weakness invades the neck muscles the head cannot be supported, and the diaphragm sometimes ceases to act. Fortunately, the paralysis rarely reaches its height in the two sets of respiratory muscles at the same time." In this particular case, I think, the slow onset and progress of the intercostal paralysis, and the over action of the diaphragm,

prevented the development of these dangerous pulmonary symptoms. The long duration of the paralysis, and the comparatively rapid recovery, accord well with what is met with in some cases of diphtheritic paralysis; and I think that, all things considered, this is the most satisfactory diagnosis. What part the arsenic played in bringing about recovery I am not prepared to say, but still it was very remarkable how quickly improvement did take place when the drug was given to the patient after she had remained *in statu quo* for nearly 18 months under various kinds of treatment. At the same time, she was having the faradic current applied to both sides of the chest every day for 15 or 20 minutes. This probably had more effect in relieving her than the arsenic.

CASE OF TETANUS FOLLOWING TYPHOID FEVER.

BY ÆNEAS J. McDONNELL, M.B. et CH. M.
SYD., RES. SURGEON TOOWOOMBA HOSPITAL,
QUEENSLAND.

W. W., aged 18, was admitted July 12th under the care of Mr. Sheaf, F.R.C.S., suffering from typhoid fever.

On August 16th temperature was normal, and on August 28th patient got out of bed for the first time, being very weak.

I was away from the hospital, but was sent for, as the patient had been seized with "convulsive fits."

On arriving I found patient had got up about 2 p.m. About 2.30 p.m. was noticed swaying about in his chair; was put back to bed and whisky given; hardly had he been placed in bed when he had a fit, in which his body formed a perfect arch. Three of these attacks occurred before my arrival. When I saw him he was quiet, "risus sardonius" well marked, complained of pains in masseters, wrists, and down legs.

Gave chloral hydrate gr. xx at once, and an enema, which acted well.

Shortly afterwards I saw him in a spasm. It began in the masseters. There was chattering of teeth, then marked trismus, head drawn back, arms rigid, and finally marked opisthotonos, which lasted about two minutes, and then the rigidity disappeared in the inverse order of its occurrence; temperature 99° F. Fearing the depressing action of chloral on the heart, gave urethane in gr. xx doses every two hours. After using half an ounce I had to fall back on chloral.

August 30.—Put patient in blankets wrung out of very hot water every two hours, and kept

this treatment up for twenty-four hours. In all patient had about twenty-five opisthotonic seizures in twenty-four hours; trismus became almost constant; at odd times when jaws relaxed was able to swallow with difficulty, was unconscious, to be fed by the bowel—egg, brandy, and chloral $\frac{1}{2}$ a drachm every three hours. Urine drawn off by catheter, temp. 99.4.

August 31.—Passed fairly good night, trismus constant, head drawn back, muscles of deglutition rigid, arms stiff as a board, and had four or five opisthotonic fits during night. During all day no seizures, so chloral not given.

September 1.—Trismus still constant, patient moans at intervals, fits began this morning, chloral to be continued, temp. 99.6° F.; in evening pulse got very faint, breathing like Cheyne-Stokes, chloral stopped entirely now.

September 2.—Passed quiet night, trismus still present, arms not rigid nor muscles of neck.

About 10 a.m. grew very livid and cold; hot-water bottles to feet. All this day pulse just felt at wrist; breathing very shallow; face very cyanosed. To my astonishment he lasted on.

September 3.—Pulse slightly stronger; gave enemata of beef-tea, egg and brandy every three hours; pulse stronger at night; is getting warmer; cries out at times; still unconscious.

September 4.—Had a good night; was conscious and able to swallow small quantities of food; felt very weak and complained of pains all over him. In evening, severe frontal headache, temp 100.4. Temp. ran up to 101° F. next evening, but after this had no complaints except of weakness in his legs.

September 10.—Is now up, but legs are still weak, and cannot walk very far yet. Discharged on Sept. 20, cured.

Remarks.—P. states that four years ago, in Germany, had a similar attack, which lasted for some weeks; was told he had tetanus, and examined for a wound which was not to be found. Has been in good health ever since.

Are there any other cases on record of tetanus having occurred twice in the same individual? In the second attack the "materies morbi" (whatever it may be) seems to have lost some of its power, judging from the shorter time the attack lasted.

I tried nitrite of amyl capsules during the paroxysms; the first acted well, but after that they had not the slightest effect.

Chloroform seemed to check the seizures, and I aborted two or three by means of it. There was complete retention of urine for four days. It was perfectly impossible to do as Macnamara in Quain's Medicine suggests, and feed the patient by the mouth as well as the rectum.

PROCEEDINGS OF SOCIETIES.

SOUTH AUSTRALIAN BRANCH OF THE BRITISH MEDICAL ASSOCIATION.

Monthly meeting held on September 26, 1889. Present: Drs. Cleland (President), Clindening, Davies-Thomas, Verco, Niesche, Stewart, Singleton, Archer, Hayward, London, Symons and the Hon. Sec. (Dr. Poulton).

DR. T. K. HAMILTON shewed a shrivelled eyeball he had enucleated with "Deposit of Bone on the Choroid."

The eyeball was removed from a girl aged 19 years, who when three years old had sustained a severe injury with perforation of the right eye, which resulted in complete destruction to sight and subsequent shrinking.

On making a section of the globe, a thick bony cup is found filling up nearly the whole of the posterior chamber, its convexity resting on the choroid. There is a small perforation of the cup near its centre, through which a connection is formed by a band of soft material, between the region of the disc posteriorly and a quantity of broken down tissue filling the concavity of the cup anteriorly. This band is probably the remains of the atrophied retina, which remained attached round the disc, when the rest of the retina became detached and pushed forward by the ossific deposition and growth between it and the choroid.

The eyeball was removed to prevent sympathetic mischief to the other eye, as rather frequently recurring attacks of pain and tenderness were coming on in the shrunken globe.

Minutes of previous meeting read and confirmed.

The HON. SEC. reported that at a meeting of practitioners, held the previous week, a committee consisting of Drs. Hayward, Gardner, Stirling, Corbin, A. A. Hamilton, J. A. G. Hamilton and Poulton, was appointed to consider further the question of medical legislation, with power to report to the Branch.

DR. VERCO read a paper on a case of tumour of the brain as follows:—

TUMOUR OF THE BRAIN—DEATH—POST-MORTEM.

REPORTED BY DR. VERCO, HON. PHYSICIAN TO THE ADELAIDE HOSPITAL.

J. R., *æt.* 52, married, brassmoulder, born in England, eight years in the colony; was admitted into the Adelaide Hospital on June 5, 1889, under the care of Dr. Verco. He was well till eight or nine months ago, when he began to be weak in the back and had some pain in the right leg; no specific history. He cannot stand with his feet close together, and falls when he shuts his eyes. There is no paralysis of face or arms or legs, and no loss of sensation. The knee jerks are absent; there is no ankle clonus. The plantar, cremasteric, abdominal, and epigastric reflexes are present. There is frequent hiccough, and some headache; passes his urine involuntarily at times. It is acid, with a whitish sediment of mucus, no albumen, excess of phosphates or sugar.

16th August, 1889.—His eyelids, when he is looking directly before him, are about the eighth-of-an-inch above the upper edge of the cornea, and there is convergent squint with an occasional convergent spasm. On carrying an object either to the right or left the eyes follow it with a horizontal jerky nystagmus movement. They can look downwards for some distance, but they cannot be raised above the horizontal. In the right eye the disc is very indistinct at the margins; the veins and arteries can be plainly seen, but along the vessels there are whitish streaks; the disc is almost of the same colour as the fundus, and the vessels are blurred and indistinct over the papilla. In the left eye the disc is more indistinct.

24th June, 1889.—Had a sudden fit of vomiting last night. His fits of emesis nearly always come on very suddenly.

27th June, 1889.—Another attack of vomiting.

28th June, 1889.—Passed water in bed twice unconsciously; complains of general headache.

1st July, 1889.—Sight failing.

5th July, 1889.—Pain in calf of leg; has never had severe or lightning pains in the limbs or body; vomits nearly every day; has some perception of objects in the left eye; of light in the right. When at rest the right eye diverges slightly; discs swollen; veins enlarged and tortuous; cedema of retina around the discs.

9th July, 1889.—Had the patient dressed, and made him get out of bed. He managed with difficulty to rise to the erect posture, but could hardly stand alone; much weakness in the legs, the knees giving way. The left leg seems slightly stronger than the right. He is very staggering, and tends to fall backwards. Right hand squeezes less strongly than the left.

26th July, 1889.—Vomiting and hiccough continue. The latter seems to be provoked by any attempt to move himself; lies always on his right side, but can turn himself easily; protrudes the tongue slightly to the right of the middle line.

2nd August, 1889.—Is weaker and more drowsy.

12th August, 1889.—Complains of pain at times in the hips and knees. His legs seem almost powerless. When they are straight in bed he cannot draw them up. They are not stiff to passive movement, though he complains of pain at the knees when these are bent. All urine is passed in bed. Bowels do not act without enema; epistaxis twice, not profuse.

13th August, 1889.—Urine acid; no albumen, sugar or phosphates.

17th August, 1889.—Blisters on heels and over hips.

20th August, 1889.—Face drawn slightly to the left side when showing his teeth, but the left palpebral fissure seems rather larger than the right when the face is at rest.

28th August, 1889.—The superficial reflexes are all abolished except the plantar. There is no knee jerk, no reaction of pupils to light. He is quite blind.

27th August, 1889.—When told to look upwards the eyes do not roll up, but both move inwards in a jerky manner, and the left rolls slightly downwards as well.

1st September, 1889.—Died.

The diagnosis made was a tumour of the cerebellum, in the middle lobe, close behind the corpora quadrigemina, probably not syphilitic nor tubercular, but the exact nature unknown.

Post-mortem.—On examining the brain there was found a growth in the fourth ventricle. It was quite circumscribed, triangular in shape, measuring nine millimetres longitudinally, and ten transversely. Its apex was forward, and its base was somewhat overhanging. It was reddish brown in colour, and very soft in consistence. It sprang from the upper or posterior surface of the pons. The apex was immediately behind, but quite separate from the posterior corpora quadrigemina and close to the iter a tertio ad quartum ventriculum. The base was immediately under the main trunk of the arbor vitæ of the middle lobe of the cerebellum. The upper posterior or free surface of the tumour was therefore in contact with the valve of Vieussens throughout its whole extent, and the anterior foliaceous portion of the middle cerebellar lobe lay over the tumour, but separated from it by the valve of Vieussens. The valve was completely unattached to the growth, and not visibly altered in any way; nor was the anterior cerebellar lobe or the corpora quadrigemina affected. In fact, the only abnormality was this growth projecting from the floor of the fourth ventricle. On replacing the parts it was apparent that it was moulded to the shape of the upper part of the cavity, and therefore must have exercised some pressure on the valve of Vieussens and the middle lobe. The existence of this pressure was further indicated by the manner in which the inferior part of the tumour overhung, as though it had grown upwards towards the middle lobe, but had been pressed back towards the lower unoccupied portion of the ventricle. Close to the right inferior angle of the tumour was a round accessory nodule as large as a millet seed.

There are several points of very great interest in this case.

Firstly, it is remarkable that a growth of such small size should determine death. The fact is

explained by its situation in the pons adjacent to structures essential to the maintenance of life.

Secondly, the intensity of the optic neuritis, which was so rapid and so severe as to completely destroy vision for objects and almost to obliterate the perception of light. This, however, is not an isolated case, and a small tumour of the pons is recognised as a sufficient cause for such an effect. Still it is interesting, specially when contrasted with the specimen shown at our last meeting of a tuberculous growth in one side of the back of the pons, even larger than this, and associated with seven other tumours in different regions of the brain, and without any optic neuritis whatever. It proves the necessity for some intermediate condition which can serve as a link between the tumour and the inflammation of the retina and papilla.

Thirdly, the absence of the knee jerks was marked and persistent. I am not aware whether it has ever been observed before in tumour of the pons. It has been noticed in cerebellar growths. Gowers writes, in his "Diseases of the Nervous System," vol 2, page 290: "In cases of tumour of the middle lobe of the cerebellum the knee jerk cannot be obtained. Its loss is not usually constant; a slight movement can be elicited at times, and at other times none. We are not at present able to explain this curious symptom. Since it is observed only in cases of irritating disease, it is probably the result of some influence exerted on the spinal centres, on which the knee-jerk immediately depends. We may note that the path from the sensory muscle-nerves, on which the myotatic irritability immediately depends, probably goes to the cerebellum, and the centripetal impression from the muscles influence co-ordination. It is interesting also to compare the loss of the muscle reflex action in cerebellar disease with the loss of superficial reflex action in disease of the cerebral hemisphere; each is apparently the result of an influence exerted on the spinal reflex centres." It was this circumstance which determined my localisation of the growth in the middle lobe. Now the question arises whether this abolition of the knee-jerk was due to the pressure of the growth upon the middle cerebellar lobe in my case, so producing the same result as if the growth were in the central lobe, or whether in the instances of tumour in the middle cerebellar lobe, in which the knee-jerk was absent, this was due to pressure on the pons. The analogy, which Gowers points out, between the control of the superficial reflexes by the cerebrum, and the deep reflexes by the cerebellum, is suggestive. If we can push the analogy, we might suppose the existence in the lower part of the pons, or in the medulla, of an inhibitory

centre for the deep reflexes, analogous to that supposed to exist for the superficial. Then an irritating growth, such as the one I describe, by irritating this centre, would inhibit the deep reflexes; or if situated above this centre, *i.e.*, between it and the cerebellum, would cut off the cerebellar control of this centre, and thus free it to inhibit to its full power; and so by the double effect of severing the pontic or medullary centre from cerebellar control, and irritating it at the same time, completely abolish the knee-jerks. But, apart from theories, the fact for diagnostic purposes remains, that absence of knee-jerks does not necessarily indicate cerebellar tumour; it may be induced by a growth springing from the back of the pons *towards* the cerebellum.

Fourthly, one prominent symptom in the case was *loss of the upward movement of the eyes*, without affection of the levators of the upper lid. This enabled me to locate the tumour as just behind the corpora quadrigemina. This I did from the information given in the following extracts:—"Paralysis of the upward movement of the eyes may result from disease of the posterior part of the third nerve nuclei, and is then associated with paralysis of the levators (Kahler and Pick). When due to a focal lesion it is usually unilateral. It is possible that there is also a higher centre, disease of which may paralyse the upward movement without the levator, since the isolated symptom may be met with. I have recorded one such case, in which the symptom was well marked."—Gowers' *Dis. of Nervous Sys.*, vol. 2, p. 174. On referring to this case in his *Medical Ophthalmoscopy*, 2nd edition, 1887, p. 340, it appears that there was "remarkable defect in the upward movement of both eyes. In other directions they moved freely, but when she tried to look upwards they moved little, or not at all, above the horizontal line." He diagnosed a tumour in the middle line, interfering with the function of the centre for upward movement of the eyes. From other symptoms he concluded there was disease of the middle lobe of the cerebellum, pressing on the medulla; and this agreed with the experiments of Ferrier, which located a centre for upward movement of the eyes in the middle lobe of the cerebellum. When the patient died, "a very small tumour was found in the middle line behind the posterior quadrigeminal bodies, damaging these slightly, the velum and the adjacent part of the inferior vermiciform process of the cerebellum." "It must be remembered that disease of the nerves or their roots may chance to affect only the fibres for the superior recti. This was apparently the case in a patient with interpeduncular syphiloma (Thomsen). One superior rectus was more affected than the other, a character that is probably of diagnostic

importance."—*Dis. of Nerv. Sys.*, vol. 2, p. 174. "In most cases of disease of the tubercula causing palsy of the ocular movements, the lesion has extended so deeply as to involve the nuclei of the third nerves," p. 287. Now from these quotations we learn that the loss of the upward movement of the eyes, if associated with paralysis of the levatores palpebrarum, may be due to affection of the nuclei of the third nerves which *lie in the floor of the 4th ventricle*, considerably above the situation of my tumour. A unilateral affection of the superior rectus and levator palpebrarum might be caused by focal lesion of one nucleus. Also that both superior recti may be affected by disease of those parts only of the roots or trunks of the third nerves which supply the superior recti muscles—as from syphilitic disease; but in these cases one nerve would, probably, be more affected than the other, and, probably, limitation to the superior recti would only be a stage in a gradually increasing palsy of the third nerves. But there appears to be a centre which affects the upward movement of the eyes, and which is distinct from the nuclei of the third nerves, and which does not lift the lids. The exact situation of this centre is uncertain. "It has been shown by Adamuk that irritation of certain spots in the corpora quadrigemina produces, severally, elevation and depression of the eyeballs, and conjugate movements to the right and left."—*Theory and practice of Medicine*, Bristowe, 5th edition, p. 1080. Ferrier localised upward movement of the eyes in the upper vermiciform process of the cerebellum, at the anterior extremity, in the middle line. Gowers' case seems to support Ferrier's localization. My case seems to confirm Ferrier rather than Adamuk. For the pressure of the growth was evidently on the middle cerebellar lobe rather than on the posterior tubercles. One might be inclined to suggest the possibility of the existence of the centre for such elevation of the eyes, in the pons, and its direct affection by the growth in this part; but the evidence from Ferrier's experiments of a whole series of centres in the cerebellum, for the control of various associated movements of the eyes, is so strong that I am more inclined to believe my pontine growth affected the elevation centre in the middle lobe of the cerebellum, indirectly, than that such a centre exists in the floor of the fourth ventricle.

Fifthly, the existence of such a growth of the fourth ventricle, without producing more extensive paralysis of cranial nerves, is instructive. When we consider how closely and intricately the many nerve nuclei are grouped there, it seems strange how they could have escaped. But yet it is easily explicable. For if a diagram of the fourth ventricle be examined in which these

centres are displayed, it will be remarked that whereas the posterior half of the lozenge-shaped space is crowded with nuclei, numbered from the fifth to the twelfth, the anterior part is almost free; the motor and sensory nuclei of the fifth lying to its outer angle, while the third and fourth nuclei lie beneath the iter, and therefore outside the ventricle. Now it is just in this vacant area that our tumour originated, and hence the freedom from paralysis of the cranial nerves. There was only a suspicion of partial palsy of the lower part of the face on one side, and of the upper part of the face on the other, and of the existence of this one could not be sure.

I may say the patient was treated for a long time with 80 grain doses of pot. iod. four times a day, not because the tumour was believed to be specific, for it was considered not to be; but as a forlorn hope, and, of course, without benefit. The diagnosis of its situation, also, ruled out operative interference as impracticable.

DR. HAYWARD then read the following paper on a case of acute yellow atrophy of the liver.

A CASE OF ACUTE YELLOW ATROPHY OF THE LIVER.

BY W. T. HAYWARD, M.R.C.S., L.K.Q.U.P.,
HON. PHYSICIAN ADELAIDE HOSPITAL, AND
HON. PHYSICIAN ADELAIDE CHILDREN'S
HOSPITAL.

CASES of this disease are so rarely met with that I feel it incumbent on me to bring the following case under your notice.

On Tuesday, December 18, 1889, I was called to see Mrs. H., aged 24, a young married woman in easy circumstances. I found her sitting up, fully dressed, complaining of rather acute pain over the region of the liver.

Previous history.—Was a strong hearty girl till she was twelve years of age, when on a voyage from England she had a severe attack of quinsy, which left her very weak for some time afterwards; since then she has been frequently ailing. Has had frequent attacks of hysteria for two years, used frequently to lose her voice, sometimes for a couple of months at a time, for which disease she was under the care of several medical men in Adelaide. Has suffered from peculiar somnolent symptoms, her mother says that at times she would without warning drop off into a sleep from which she could not be awakened; this condition would last for about six hours, when she would awake and appear quite well; these attacks would occur irrespective of time or place. Has of late years suffered acutely from dyspepsia, the pain

from which would only be relieved by taking whisky neat, she would sometimes take two or three glasses, one after another. At this time she was employed as a barmaid, but she has not been in the habit of taking stimulants to excess.

History and present condition.—Patient is well nourished and apparently a strong, well formed young woman. She has resided at Broken Hill since her marriage, which took place in May last (1888), from which time she has enjoyed fairly good health. Became pregnant last July, has not suffered from the usual symptoms of pregnancy. Three months ago received a severe mental shock owing to the sudden death of a near relative; a fortnight later she was seized with violent vomiting which continued for three days and left her prostrate. She stayed in bed for a week and remained rather weak for sometime afterwards, but suffered from no definite symptoms. Came to Adelaide three weeks ago for change of air. Her mother says that since she has been with her she has been very well, and her husband says that on his return from Melbourne on Thursday last, he had never known her better. On Saturday last she complained of feeling poorly, but went about as usual till Monday, when she began to suffer from pains over the region of the liver, which increased in severity on Tuesday, when she vomited once. When seen by me on that day she described these pains as somewhat lancinating, and they were increased by pressure over the part. On percussion the liver dulness was apparently slightly increased in extent of the normal, and the sense of resistance greater than natural. No other abnormal abdominal signs were present. The skin and conjunctivæ were decidedly jaundiced, but not markedly so. There was no headache, and the mind was perfectly clear. There had been no rigor. Tongue slightly furred. The motions were described as pale coloured and rather constipated. The urine decidedly dark, and contained bile. Temperature slightly above the normal, pulse between 70 and 80.

I sent her to bed and ordered poultices to be applied over the liver, prescribed a mixture containing sulphate of magnesia and tincture of hyoscyamus.

Wednesday,—Has slept badly and been restless; complains very much of the pain. Jaundice more marked. Motions and urine as yesterday. Pulse 74, temperature normal. Prescribed pil. morph. mur. gr. $\frac{1}{4}$, to be repeated should pain become severe.

Thursday,—Complains a good deal of the pain and seems somewhat unreasonably querulous; no headache or shivering; tongue coated slightly; no vomiting; takes light food; bowels consti-

pated; urine as before; pulse 80; temp. normal; jaundice as before.

Friday.—Slept better, and is apparently decidedly better; motions still pale coloured, but urine clearer.

Saturday morning.—Slept fairly well till 5 a.m., when she became very restless and complaining, and had some fits of screaming. It is impossible to make out from her what is really the matter; temp. normal; pulse 84.

Afternoon.—Has had fits of violence, almost maniacal, succeeded by apparent unconsciousness; had a violent attack in my presence, during which she struggled violently, endeavouring to get out of bed, on my resisting her she seized hold of my coat with her teeth and shook it, and afterwards tried to bite my leg; on letting her get up she staggered to the door of the room, and on being prevented from going out she sank down on the floor and lay there till she was put back to bed; jaundice not so marked; tongue coated with blackish fur, but quite moist; trace of colour in motion; urine clear; pupils seem more dilated than natural.

Midnight.—Violence continues; has not spoken rationally during the day; throws her arms and head about a great deal and makes attempts to get out of bed; is continually crying out "My God!" no vomiting; pulse 90, fair; temp. normal; urine contains no bile nor albumen; some phosphates; liver dulness, apparently less than normal; cardiac sounds normal; a few large râles heard over the lungs. Dr. Lendon saw patient with me.

Sunday morning.—Passed a very restless night; is unconscious; violence continues, but with abated force; passes her water under her; no vomiting; bowels have not been moved; pupils dilated, regular, and act sluggishly to light; temp. normal; pulse 96.

9 p.m.—Comatose condition; has passed a black motion under her; urine very dark colour; no vomiting; temp. 100.2; pulse 96, small; liver dulness, three fingers breadth; respiration rapid; râles over chest; pupils acting very sluggishly, dilated; reflexes diminished, but not absent; swallows badly. Dr. Gardner saw the case with me.

Monday, 8 a.m.—Had had a miscarriage, apparently had pains for half-an-hour previously; child and placenta expelled together; very slight hæmorrhage; blood normal colour; violent vomiting of thin black fluid ensued; pulse and respiration very rapid.

Vomiting continued incessantly till 5.30 a.m., when she died.

With extreme difficulty I obtained permission to examine the liver; but that being the extent

of the permission, I was only able to make a most imperfect *post mortem* examination. On opening the abdomen there were no signs of peritonitis to be found. The liver was not adherent to the parietes. On removal it was found to be small, but the atrophy was not more marked in one place than another; it turned the scale at $8\frac{1}{2}$ oz. On section it was soft and friable; had an oily appearance and a bright yellow colour. The spleen was somewhat larger than normal, and the kidneys healthy. I was unable to make any further examination.

Remarks.—Never having before seen a case of acute yellow atrophy of the liver, I have no hesitation in confessing that it was not till the Sunday that I fully recognized the nature of this one, though my suspicions were aroused on the day previous. On first seeing the case I diagnosed it as one of hepatitis, involving the capsule, and I had no reason for doubting the correctness of my opinion till the Saturday, for, up till that time, it seemed to be running an ordinary and uneventful course. The objective signs were slight: The temperature normal; pulse only slightly increased, of fair quality; the jaundice trivial; bile not altogether absent from the fæces, and the bile in the urine gradually lessening, in fact, there was nothing to indicate the gravity of the case till the Saturday, when the cerebral symptoms began to manifest themselves. In recounting the "previous history," I have dwelt rather fully on the hysterical nature of the patient, who seems to have suffered very severely from this disorder, and I have purposely done so because when the screaming fits, &c., that I have recorded began to show themselves, I had no hesitation in ascribing them to another outbreak of the old enemy, though as the day progressed, I had considerable misgivings as to the correctness of my opinion. The attacks were too maniacal, and the condition of the tongue and the pupils seemed to indicate something deeper, and at night Dr. Lendon and I discussed the possibility of it being a case of acute yellow atrophy, but decided that the symptoms—taken in conjunction with the previous history—did not warrant us in making so serious and unusual a diagnosis, but on the following morning I had no doubt about the nature of the disease, in which opinion I was confirmed by Dr. Gardner later in the day. I regret that I did not examine the urine for leucine or tyrosine, but I did not think of doing so till too late.

As a curious coincidence, though not bearing directly on this case, I might mention that about ten days after the death of this patient the husband consulted me, suffering from well-marked jaundice and not a little nervous trepidation. His symptoms were decidedly more severe than

the initial ones of his wife, but though I had received a lesson as to the necessity for caution in making a diagnosis in cases of apparently simple jaundice, I endeavoured to relieve his mind by expressing the opinion that he was suffering from a catarrhal affection induced by his efforts to drown his trouble in liquids more potent than water, and the subsequent course of his case demonstrated the correctness of my diagnosis this time.

And before leaving this subject I would like to ask members if they can assign any reason for the number of cases of jaundice that occur at Broken Hill?

After a discussion, in which Drs. Davies-Thomas, Lendon and Verco joined, the meeting adjourned.

NEW SOUTH WALES BRANCH OF THE BRITISH MEDICAL ASSOCIATION.

THE 84th general Meeting of the Branch was held in the Royal Society's Room, Sydney, on Friday, 6th September, 1889, at 8.15 o'clock. Present: Dr. Fiaschi, President, in the chair; Drs. Chambers, Orago, Knaggs, W. J. O'Reilly, Newmarch, Worrall, Hankins, Shand, Cohen, Rennie, Hodgson, Scot-Skirving, Todd, West, Brady, de Lambert, Martin, Clubbe, Foreman and Wright.

The minutes of the previous meeting were read and confirmed.

Dr. SCOT-SKIRVING read some notes on a case of basal lesion, and demonstrated the various paralyses of the cranial nerves on the patient, who was examined by the members.

Dr. KNAGGS said the members were very much indebted to Dr. Scot-Skirving for his very interesting and exhaustive description of this case. Although the patient's history, so far as it was known, did not admit of syphilis, still he (Dr. Knaggs) thought it would be well to treat the case with iodide of potassium or perchloride of mercury, as the tumour was, he thought, probably syphilitic. He referred to the frequency with which the sixth nerves suffered in intra-cranial syphilis.

Dr. WORRALL said he had shown a somewhat similar case to this at a meeting of the Liverpool Branch, which, upon a *post-mortem* being held, exhibited a tumour about the size of a walnut.

Dr. RENNIE said there was one point in the history of this case, that is, the headache being worst at night, which favoured the view that the growth was syphilitic. If the tumour were of sufficient size there would, no doubt, be paralysis of the opposite sixth nerve. In its long course over the pons pressure is easily exerted upon it. In his (Dr. Rennie's) opinion this was a case of sarcoma growing from the skull.

Dr. CHAMBERS read some notes on a case of inverted uterus, and exhibited the specimen.

Dr. WORRALL said that he believed force must have been used in this particular case to have caused the inversion. It is well known that often the women in

charge of these cases are in the habit of pulling on the cord, and he (Dr. Worrall) thought something of the kind had occurred in this case, especially as this woman had already had two children. He (Dr. Worrall) remembered being called to a case, and when he arrived he found the patient standing by the mantel-shelf. The child had been expelled, and the cord had separated. In this case there was a slight inversion, which, by a little manipulation, was soon reduced.

Dr. NEWMARCH said it had often been a wonder to him that accidents of this kind were not more frequent from the careless way in which some of the midwives treat these cases. He (Dr. Newmarch) remembered a case where a woman had been advised to get on a chair and jump down to get rid of the placenta, and another case happened about three years ago in which the child was born dead, and as he (Dr. Newmarch) was leaving he noticed a great change came over the patient, and she really looked as if she were dead. On examination it was found that there was inversion of the uterus, which was reduced, and the patient made a good recovery. In this case, at any rate, no force was used.

Dr. SHAND said he had not had to do with any case of this kind except one, and that was in connection with a monstrosity. The woman had been in labour about two days when he (Dr. Shand) was called in, and with great difficulty the instruments were got over the body, and with the body came the after-birth, and partly attached to it was the uterus.

Dr. W. J. O'REILLY said he remembered one case of this character. A patient sent for him (Dr. O'Reilly), and when he arrived he found the patient in a state of collapse. A second medical man was at once sent for, but knowing the importance of time in such a case, he immediately set to work to reduce the inversion, which was accomplished.

Dr. CHAMBERS in reply, thanked the members for the interest taken in the paper read by him. He (Dr. Chambers) thought it well to bring cases like this before the Branch just to have the points of treatment discussed, and for a re-opening of the old methods.

Dr. DE LAMBERT said he had a question of medical etiquette to bring before the Branch as follows:—If a medical man is called in to consult with another gentleman what is the usage as to the consultant taking over the case.

Dr. KNAGGS said he had made a rule for his own guidance never to see a patient a second time except at the instance of the medical gentleman who has charge of the case. It is impossible to lay down a hard and fast rule in the matter; but he (Dr. Knaggs) thought the best plan was to do as you would others to do unto you.

Drs. FOREMAN, HODGSON AND SCOT-SKIRVING expressed the same opinions as Dr. Knaggs.

Dr. DE LAMBERT thanked the members for the expression of opinion, and said he was glad to know that the same rule which he had been used to in France obtained here.

Dr. CLUBBE said he was prepared to submit his resolution with regard to the agreement between medical practitioners and Friendly Societies; but he thought it would be better to postpone it owing to the wrong copies having been distributed to the members.

It was resolved to postpone the item until next meeting.

The following new members were announced:—Dr. Warren of Camden, Dr. J. McDonagh of Sydney,

NOTICE.

The Editor will feel obliged by any gentleman, who wishes to ventilate any subject of professional or public interest, writing an editorial or leading article on it, which if found on perusal to be consonant with the policy of the paper, will be inserted in an early number.

All communications intended for the Editor should be sent to the 'A. M. Gazette' Office, 35 Castle-reagh Street, Sydney.

*** Contributors can have their Papers reprinted and published in Pamphlet form, at Cost Price, if the necessary instructions are given to the Publisher at the same time the contributions are sent in.*

AUSTRALASIAN MEDICAL GAZETTE.

SYDNEY, OCTOBER 15, 1889.

EDITORIALS.

THE QUEENSLAND IMMIGRATION SERVICE.

THE defects in any system of immigration are of three kinds, and may for the sake of classification be divided into, (a) Medical (including sanitary defects), (b) Moral; and (c) Those affecting the personal comfort and well being of the emigrant, which, for want of a better definition, may be termed social. Under these headings, therefore, it is proposed to consider the preventible shortcomings of the Queensland Government Immigration Service.

(a.) In any colony in which the Government is directly responsible for the greater proportion of its immigrant population, it behoves those in authority to exercise all possible care to prevent the introduction of contagious and infectious diseases. We have already, in a former article upon Federal Quarantine, urged the necessity of this, and it now remains but to shew in what way it applies to the present subject. It seems to us that the depôt at present in use at Blackwall might with advantage be abolished as a receiving house for Australian emigrants. The locality is unhealthy in itself, and although the actual buildings are suitable the sanitation in general leaves something to be desired, moreover to reach this depôt the most insanitary and overcrowded portion of London has to be passed through; the railway carriages in use on the line between Blackwall and Fenchurch-street being those constantly carrying the residents of this district, in which it is not too much to assert contagious and infectious disease always more or less prevails. It appears therefore that the Government of Queensland made a step in the wrong direction when

they moved their depôt from Plymouth to Blackwall. Indeed this is rendered still more evident when the passage down the English Channel is considered, for no one would be so venturesome as to deny that this portion of the journey is fraught with more danger than all the rest of the voyage put together. Another argument in favour of Plymouth as a departure port for emigrant vessels is the fact that at starting even on board the best regulated vessels, things, generally are in more or less confusion, and a day or so is required to get into working order by those in charge; if, therefore, the ship went round from London to Plymouth less confusion would prevail after the emigrants were put on board than does at present. A confusion so great that were an accident to happen in the Channel—a place notorious for collisions of an appalling nature—a catastrophe would ensue that would rouse even the Imperial authorities into action. It seems obvious in the face of these facts that the present depôt at Blackwall benefits no one but the shipping companies and those officials connected with the departure of the various vessels. The former since it saves the expense of calling at Plymouth and of forwarding their saloon passengers to that port, and the latter because it saves them periodical journeys of an uncomfortable character. It may be put forward that London is more easily reached by the emigrants than Plymouth, but this is only very partially true, for at present the train services to the latter place put it in direct communication with every part of England, Scotland and Wales, whilst a line of steamers from Dublin call there regularly, and give direct communication with Ireland.

Another doubt presents itself to our mind when we consider the shortness of the time allowed for the medical examination of intending emigrants, and we cannot but think that the interests of all concerned would be much better served if, instead of one day being allotted for this purpose two or more were taken up in ascertaining the bodily and mental condition of those who will form an integral part of the population of Australia. In this way only can the introduction of hereditary disease be guarded against. No doubt the surgeons employed by the Queensland Government do their best, but the time in which that best has to be done is manifestly quite inadequate. Before pointing out some of the medical defects on the vessel itself we should like to ask one question. Is the depôt disinfected throughout after the occupation of each batch of emigrants? For, although no case of infectious disease may shew itself in any particular batch while at the depôt, such may be latent and the germs thereof communicated to the succeeding one.

On the vessel itself the following items suggest a possibility of improvement. The hospitals for both sexes are respectively in the single men's and single women's compartments, partitioned off, it is true, but practically forming a portion of them. It is almost needless to say that as they at present exist in the majority of ships they are utterly useless in the event of infectious disease breaking out; nor does it require any deep or specious reasoning to prove that on board ship hospitals for either sex should be provided isolate from and independent of the general quarters. We noticed on the "Quetta" that nearly all the fittings in the single men's and single women's quarters were of iron, and we thought that this material could with benefit be more extensively employed in those of the married people. The decks were of wood and permanent, an arrangement it is to be hoped obtains in all emigrant ships; indeed, it would be difficult to imagine anything more insanitary than an iron deck temporarily boarded over, since such would become a mere cesspit for the reception and absorption of any moisture whatever, and permit the accumulation beneath it of liquids injurious to health and obnoxious to smell. Waterways at the sides of vessels also act in a similar manner and are as a rule an incentive to uncleanly habits on the part of emigrants, or indeed of any class of passenger. It is an important element to the health of those on board that such waterways should be kept constantly clean, and that the scuppers in communication with them should be at a slightly lower level, and not, as the writer has seen, in such a position that the liquid in order to escape would have to run uphill. Another remediable defect we noticed was the water supply to the closets, a main supply pipe leading forward to supply closets on both sides of the vessel being divided into two pipes of its own size, one for each side. Also, we have been told, by more than one surgeon, that on several ships the water supply leaves much to be desired. Lastly, on this head, a water closet (for night use only) similar to that of the single women's compartment should be built in the married people's quarters, as such must be absolutely requisite in rough weather, and its want sorely felt by both women and children.

(b.) The moral defects, or rather defect, limits itself to the berthing of the married people not only on the ship, but in the depôt. In the latter only a thin wooden partition separates each family, and from the centre of the dormitory only a curtain intervenes. On the former families actually sleep over each other, those underneath having the benefit of *all* that may take place in the berth above. It is not too much to say that under these

circumstances, since the majority are young married couples, that modesty is sorely tried, if it does not become a thing of the past, on board an emigrant vessel.

It is not for us to suggest a remedy, that belongs rather to the province of naval architecture; but it appears to us that a greater proportion of children and young married women would preserve more of their native modesty were the sexes divided; the married women and children berthed with the single women, and the married men with the single men; or, should this not be practicable, separate and distinct cabins with partitions from deck to deck given to each family.

(c.) *Social Defects.*—These are more numerous and can merely be enumerated, since it would not become a medical journal either to argue about them or put forward a way to ameliorate them.

The stores for the use of emigrants are good, of their kind, but tinned provisions enter largely into their dietary scale. Surely in these days of refrigerators more fresh meat and vegetables could be given at little, if any, extra cost. Another (to us) serious drawback, is that all provisions are shipped by the owners of the vessels employed and not by the Government, a feature in the system most likely to create friction between the two people chiefly concerned in the bringing out of emigrants, the captain and the surgeon-superintendent, since these represent two diametrically opposed interests; for the object of the Company is to carry the emigrants as cheaply as possible. Added to which, so keen is competition in the providing trade that the British India contract for emigrants is under £2 10s. per head for eighty days provisions, *including* medical comforts. This, we think, needs no comment.

Another grave defect is the inadequate means of saving life, in other words the boats, rafts, and spars to make rafts are not nearly sufficient. It is doubtful, nay certain, that not one emigrant ship goes to sea with boat-accommodation for more than half the souls on board, and that in the event of there being a necessity to leave the vessel, many absolutely must perish, and probably in the rush that would indubitably take place, more would be sacrificed than necessary.

Finally, the temporary character of the bath-rooms, water-closets, and booby hatches, calls for reform. None of these structures are of a strength sufficient to withstand a heavy sea; accidents have already occurred in the two former, one resulting fatally; and luck seems to have largely entered into competition with forethought, that so few casualties have arisen from this cause. There are many small items we might point out, such as the issuing-room for provisions being on

the orlop instead of the main deck, the want of a store-room on deck, one cook-house, where there should be one for each end of the ship, the channel passage its dangers and discomforts, already alluded to, and doubtless others not patent to ourselves. In conclusion we must strongly disclaim any wish whatever to reflect in the slightest upon the manner in which arduous duties are carried out by those responsible to the Government for the dispatch, &c., of emigrant vessels, what we wish to point out are the imperfections of a service that at present is unrivalled. No system can attain perfection, but if, in the course of events, this article should influence for the better that of the Queensland Government, we shall feel we have in some small way benefitted the life of the ordinary British emigrant, and raised the service from a standard already high to one even higher.

VACCINATION.

WE have from time to time drawn attention to the neglect of vaccination in New South Wales, and we have contrasted the unprotected state of that Province with the state of England and of Germany. We have also shown in the case of those two countries how gradually accumulated experience has led during some years past to the enactment of more and more strict regulations, how those regulations have practically operated, and how in Germany smallpox has decreased coincidentally with the more thorough vaccination of the people, until this disease may not unfairly be said to be abolished there to-day. These and other lessons, however, remain unregarded in New South Wales; the people are indifferent, the Government without prevision; and the year 1888 furnished a vaccination return of what we must now call the usual kind—that is to say that with a number of births which was something like 38,000, the successful vaccinations performed at all ages under the voluntary system in force were no more than 2,069. The state of affairs thus indicated is obviously a standing menace to the whole of Australasia; and as the question involved is the intelligent appreciation of facts furnished by the prolonged experience of many countries, we venture to draw a comparison although it may not be found flattering. During a long series of years the Government of New South Wales has not found time to turn

any attention to the question of compulsory vaccination, which in the civilized countries of Europe is deemed so pressing; but the Japanese have had since 1886 a very stringent and carefully administered compulsory vaccination Act, of which some account is furnished below. So that it appears that the rulers of the Empire of Japan either have more leisure than the Government of New South Wales, or else have a shrewder appreciation of the true basis of national prosperity. We do not pretend to decide which is the right explanation, for it seems certain, on the one hand, that it must be more difficult to govern very many millions than one, while on the other it cannot be admitted that the value of human life is really thought to be less here than in a country whose most widely known institution thus far is, perhaps, the happy despatch.

From an Imperial decree promulgated in November, 1885, to take effect from January 1, 1886, which is published in that admirable little journal the *Transactions of the Sei-i-Kwai*, we learn the following particulars concerning the performance of vaccination in Japan. It does not appear that it is gratuitous, although some provision must be made for the poor, for that it is compulsory is abundantly evident. In the first place all children must be vaccinated within the first year of age, and if this primary operation should turn out "inefficient" it must be repeated a second or third time in the course of the ensuing year. The next article orders that children shall be re-vaccinated "between five and seven years after the primary vaccination," and also between five and seven years after the secondary; and the effect of this regulation appears to be that children successfully vaccinated during the first year of life shall be re-vaccinated at the sixth or seventh year of age, and a second time at the eleventh, twelfth, or thirteenth year. Those are the directions for compulsory vaccination and re-vaccination in ordinary. But, when there are "signs threatening an epidemic of small-pox," children shall be vaccinated at such times as the officers may notify, without regard to the routine instructions. Ample powers being thus granted for general vaccination both in ordinary and at special times, provision is made for the exceptional cases in which sickness prevents compliance with the law; and it is ordered that a certificate to that effect "shall be sent" to "the local officers" signed by a "physician, or by a relative or neighbour." Those who are accustomed to the precise language in which our laws are expressed may well wonder how this section of the decree works; but doubtless a thorough knowledge of local conditions would reveal safeguards against the

evasions which at first sight it seems almost to invite. Next, the vaccinated person is compelled to attend for inspection on the day which may be named by the physician; and, as it must now be clear to our readers that the Japanese are nothing if they are not thorough, they will be prepared to hear that the patient "will not be allowed to object to the lymph being taken when required." Nor is this subsequent inspection left optional with the physician; he "shall afterwards examine the vaccination to determine whether it is or is not efficient," and shall give a certificate accordingly. The responsibility for compliance with these regulations is laid upon those who have the care of persons under 16 years of age, and in the case of poor-houses or orphan-homes it falls upon the chief officers thereof. Lastly, the vaccinated person shall obtain from the physician a certificate, and shall "present the same at the local office." Neglect to obey any of these regulations is punished by a money fine, which is the same for physician and patient alike. The decree includes sections by which city and prefectural authorities are required to prepare detailed instructions for the practical application of the foregoing regulations which are to be presented to the Minister for Home Affairs; and they are also to prepare statistics of vaccination and present them in January and July of each year. So that in Japan ample powers are conferred by this Imperial decree for the performance of vaccination and re-vaccination at regular times, and of special vaccinations and re-vaccinations in times of epidemic; for inspection of results; for maintaining the stock of lymph; for recording the work done; for regular transmission of the record to a central office; and for making regulations or by-laws to describe and fix the practical details of organization and method. It would be interesting to examine the latter, and to compare them with the work accomplished during the last four years; this may form the subject of a future article. It must suffice to say here that want of energy is not among the faults of this nation.

We gather from other sources that regulations for vaccination were promulgated in Japan, in 1876; but they were partial in their scope, and insufficiently stringent. Nevertheless, the results attained by them, imperfect as they were, led the Government to extend their action and to improve the powers of compulsion they conferred as soon as it was perceived—during the years 1884-5—that small-pox was attaining serious proportions among those of the population who had evaded the law. This, in short, is the circumstance to which we especially draw attention; that experience of vaccination in Japan led to exactly the same

result as in England: long ago, and in Germany, more recently—namely to greater stringency in compelling vaccination. In drawing attention to this fact our duty is fulfilled. We do not expect that in consequence, a Vaccination Act will be immediately passed in New South Wales, where at present vaccination cannot be enforced on any person, or under any circumstances whatever; but the day of reckoning is probably not far distant now, and we take care that the people shall not then count the medical profession amongst its debtors.

MANAGEMENT OF LUNATIC ASYLUMS IN NEW ZEALAND.

DR. HACON, in a spirit of philanthropic self-sacrifice which we cannot too highly commend, has drawn up and circulated for signature in New Zealand a petition to the Legislative Council of that colony, setting forth a number of circumstances which he is of opinion render a change in the present system of control of lunatic asylums in that colony desirable. With a large proportion of them we fully agree, but there are others, we think, open to some criticism. We republish the following letter, written by Dr. Hacon to the *Christchurch Telegraph*, on the subject which is of general interest:—

Sir,—In the interests of the insane of this colony I thank you for your notice of the petition *re* the treatment of the insane in New Zealand.

You doubt the wisdom of my taking the initiative; possibly you would also doubt the wisdom of my refusing £800 a year in Wellington under the present Inspector. I was formerly one of the medical officers of the Warwick County Lunatic Asylum, England. In 1879 I was travelling through New Zealand, and was asked to take charge of the Sunnyside Asylum by the Hall Government, by Canterbury people, by the Inspector, and by Mr. Seager. I was not particularly anxious to remain, but was persuaded, on the understanding that the New Zealand House of Representatives had voted special sums to procure gentlemen of experience in lunacy from England, to act as Inspectors and Medical Superintendents.

Dr. Grabham, the second English Inspector under whom I served, after three years declined, for very good reasons, to continue to act for the New Zealand Government, Mr. Buckley being the Colonial Secretary at that time. Then the Stout Government appointed as Inspector, without public advertisement or public competition (contrary to previous custom), a professor of philosophy and political economy, who had never resided or had any experience as Resident Medical Superintendent in any large Lunatic Asylum.

This Inspector wanted me to discharge experienced and respected officers and attendants. Being unable as a Civil servant to refuse to obey orders, I resigned and claimed compensation, politely intimating by my action in this matter that the Inspector might do his own dirty work himself, or find some other and more willing tool for his purpose.

To move in this matter may mean to me, I am well aware, loss of income and the possibility of making enemies. All my life I have been interested in lunacy, and shall continue to take an active interest in the welfare of the insane. You say in your article that "abuses may exist unknown to the inspector." I reply that inspectors should be conversant with recognised rules of asylum management, of which I will quote a few in order that you may be able to judge whether I am justified in writing while the Inspector is silent on such important matters (*vide* Inspector's report, which may be obtained at any bookseller's, price 1s.)

1. All asylums of more than 250 patients require a second (or assistant) medical officer.

2. Necessary inquiries *re* female lunatics cannot in common decency be made by a single man of a single woman, not even if he is a doctor and she a matron.

3. *Re* inquests. In the United Kingdom inquests are open to the public. The Commissioners in Lunacy also insist on *post-mortem* examinations.

4. All asylums in the United Kingdom are under the control of Committees of Management.

5. Criminal lunatics should be properly kept within bounds, and not afforded means of escape. They are not confined in gaols.

To Mr. Seager belongs the credit of first removing lunatics from gaols in New Zealand. Now an endeavour is being made (*vide* Inspector's report) to try and confine lunatics in gaols, specially selecting the Addington Gaol—a most unsuitable place.

You must remember that the Minister is in the hands of the Inspector; the Minister knows nothing of lunacy, and is advised by the Inspector.

Re Economy—Dr. Graham decided that 11s 6d should be the weekly rate of maintenance for lunatics. The relations of the insane are now smarting under nearly double rates of maintenance, £1 per week. In my opinion this is an unnecessarily high rate, and presses very heavily on many families in poor circumstances, who are threatened by circular with exposure of their private affairs in the Resident Magistrate's Court if they do not consent to pay.

Whether you condemn me or not, I claim the right to speak.

I am, &c.,

W. E. HACON.

ALLEGED DEATH FROM BLOOD POISONING FOLLOWING ON VACCINATION.

In the Melbourne *Argus* of September 12, appeared a paragraph relating to the death of a child named Edward Hooper, aged five months, which was alleged to have resulted from "blood poisoning, the effect of vaccination." A coroner's inquest was held the next day, a *post-mortem* examination having been carefully made. The jury after a brief retirement brought in a verdict "that deceased died from natural causes, namely, congestion of the lungs."

We think it necessary to call especial attention to this case, for we have no doubt that it will in a short time be quoted by the anti-vaccinationists as an undoubted case of death resulting from vaccination.

LETTERS TO THE EDITOR.

ADVERTISEMENT OF AN L.R.C.P. AND L.R.C.S., EDIN.

(To the Editor of the A.M. Gazette.)

SIR,—In your number of July 15th, you devote considerable space to my advertisement, and criticism thereon. There are two sides to most questions, and so it is in this case.

I trust you will in justice allow me space in your columns to reply shortly to the article referred to.

Two of my boys suffered very much from asthma, and a third from frequent attacks of spasmodic croup. I tried many remedies with more or less success. More frequently the latter. Dissatisfied with the means ordinarily used in these diseases, I resolved to see if I could not get something different and more effectual.

With that object in view I selected a number of New Zealand plants, and tested each one in the very worst cases of asthma I could find. The experimenting extended over many months. As a result of my labour I have got a combination which is extremely useful to those who require it. Since using this remedy I may say that my boys have not lost a single day from school, while before they had to be frequently kept at home and nursed.

Now having got a good thing, you say, "why not publish it, and let all medical men know the contents of the preparation. To that I would have no objection, but then some chemist might make use of it, and defeat the principal reason I have for keeping it secret. I will give the reason further on. You compare the Chamberlains and myself; I don't think the comparison holds good. The Chamberlains concealed their forceps—such as it was—and their method of using it, while I only conceal the constituent parts of my cure, while all the world are welcome to use it freely.

I quite admit that advertising is not according to the ethics of the profession, neither do I like it myself, far from it; but "needs must when necessity drives."

Let me give you my principal reason for advertising or having anything to do with a secret remedy. I am 50 years of age, and for about 25 years or more I have been suffering from Paraplegia so bad that I could not walk half a mile without the aid of a stick, and then I should feel the effects for days. Need I elaborate on this subject to show how heavily handicapped a man is who thus suffers. I have not saved any money. You can easily imagine that it must have cost me many an anxious thought as to what would be the result if I was laid up with Locomotor Ataxy, perhaps for years. What was I to do? My family too young to do anything for themselves or me.

Starve, but keep up the dignity of the profession, says your Christchurch correspondent. No thank you, say I, as long as I see an honest and independent way out of it.

The Profession here don't like it any more than I do myself, but knowing the circumstances of the case, only three have given me the cold shoulder in consequence.

You say that you are surprised to find that I am on the staff of the Christchurch Hospital. I have been so as surgeon for seven years. I have over and over again offered my present colleagues on the staff to retire if they wished it, but they preferred my remaining on. So you see, Mr. Editor, there is still some kindly feeling in the Profession even for an erring brother. I wish to retire from practice as soon as the sale of my preparation will enable me to do so; that would

not be long if only medical men would help me by prescribing my new cure, which I am sure they will find superior in the great majority of cases to anything they ever tried before. I hope I have not trespassed too much on your patience and space, but the matter is a very important one to me, more especially when you call the attention of the Colleges to the terrible departure from ordinary custom.

I am, Sir, Yours faithfully,

MACBEAN STEWART.

Christchurch, N.Z., Sept. 25, 1889.

[We sincerely sympathize with the writer in his affliction, but have nothing to add to or take away from our previous comments.—ED. A. M. G.]

THE NEW MEDICAL BILL FOR VICTORIA.

(To the Editor of the A. M. Gazette.)

DEAR SIR,—I have carefully read the Amending Medical Bill of Victoria, of which, with some slight exceptions, I highly approve.

I would call your attention to some clauses with the view of considering how they affect medical men from other colonies temporarily visiting Victoria.

Supposing a Sydney practitioner were in Melbourne would he have to pay £5 5s., or be liable to a fine if he on an emergency practised his profession during his sojourn?

Were you or I telegraphed to attend one of our patients during his sojourn in Melbourne, should we have to register before doing so? Or if we prescribed without registration would we be liable to the penalty? Is it just that a person who has paid £5 to the British Medical Council for registration in Great Britain and Ireland should have to pay a fee of £5 5s. before being permitted to practise in the Colony of Victoria?

Clause 33.—According to this clause a medical man registered in New South Wales could not take medical charge of a vessel sailing from Victoria without first being mulcted of £5 5s., so as to register in Victoria! By clause 31 every medical man going from other colonies to a Victorian Medical Congress and assuming his proper medical title, would be liable to a fine of £50, through not paying £5 5s. to Victorian Government for registration.

Clause 33.—Were I while on a visit to Victoria to attend a member of my own family who died there, my certificate would not be legal!

Looking upon the bill in this light it certainly is very exclusive, and will fall very heavily upon practitioners of other colonies who may temporarily reside in Victoria, or who may want to ship from Victorian ports as Medical Officers to ships. Believe me, yours truly,

Sydney, September 20.

M.D.

[We desire to express our thanks to our correspondent for his very useful and pertinent criticism on the proposed Medical Bill in Victoria, and commend his letter to the consideration of the promoters. We would here express a hope that some united action should be taken for the simultaneous introduction of a bill in all the Australasian colonies of such a character that when it becomes law a medical man registered in one colony would be, *ipso facto*, entitled to all the privileges and be subject to all the penalties in the others.—ED. A. M. G.]

THE COLD BATH IN TYPHOID FEVER.

(To the Editor of the A. M. Gazette.)

SIR,—In a letter that appeared in your last issue, Dr. Colpe, of Nymagee, expressed some very natural surprise as to the use of the term "icebaths" in connection with the treatment of typhoid in the Brisbane Hospital. As to the meaning of the term, I am certainly as much in the dark as is Dr. Colpe himself, nor am I in any way responsible for its use. The baths used here are usually at a temperature of 70° F., for robust cases, at least that is the temperature aimed at. During the summer months, however, the water as supplied is usually over 80° F. and is frequently as high as 86° F. Ice is then added in quantities sufficient to reduce it somewhat. But owing to the high price of this commodity, it rarely happens that the baths in summer are as low as 75° F. In the majority of cases they are found to be sufficiently cool, while baths of lower temperature are reserved for cases of intense fever. During the colder seasons of course no difficulty is experienced in giving baths at the proper heat, as the supply of hot water is always sufficient, 70° F. to 75° is then the rule.

Should it ever be considered advisable to bathe patients in iced water (i.e. water at 32° F.) I imagine the Finance Committee would have serious objections to make. It takes on an average eight or nine blocks of ice to reduce a bath containing 80 gallons from 85° to 75° F. Ice here costs 1s. a block. The cost of a bath at 32° F. would therefore have to be calculated in pounds. Considering that over 100 baths in the twenty-four hours is nothing unusual in the fever wards, the absurdity of the whole thing becomes apparent.

There is one remark in Dr. Colpe's letter which comes upon me as a surprise. He says that in Germany, since the introduction of the various antipyretic drugs, the cold bath is not used so much in cases of high and continued fever simple as in those marked by great stupor and severe nervous symptoms. Now if there is anything certain about this treatment, it is that under it this train of symptoms is hardly ever observed. During the year 1888 careful notes were taken of all the cases where delirium or stupor of any kind made their appearance. Of the 339 consecutive cases admitted, one of these symptoms occurred at some period of the attack in 30, or less than 9 per cent. Five of the 30 were cases of stupor, and were all in this condition on admission, so that in no instance did this symptom develop subsequently. Twenty-five of the 30 were more or less delirious. In 18 of these the conditions if not present on admission, only developed after some accidental complication, mainly intestinal hæmorrhage or perforation had necessitated the cessation of bathing. Of the remaining seven, two were not bathed at all, one was a case of delirium tremens in a prostitute, one acute mania with hereditary taint, while in the other three the delirium was very slight and was present for a few hours only.

Dr. Rabl's article, in the same issue, I have read with great interest. It plainly demonstrates the absolute harmlessness of this method of treatment, even with inexperienced attendants. In the south of France it is extensively used in country districts, where it has found great favour among the peasantry, for the following reasons: (1). They can apply it themselves. (2). The benefit derived by the patient from each bath is immediate and apparent to the untrained eye of any bystander, and (3) it saves the chemist's bill.

In making up his statistics, Dr. Rabl is, I think, unfair to himself. He says besides the 75 cases quoted, he had several in which the temperature only ranged

between 100° and 103°, and which, consequently, required no bathing. These he excludes as not bearing on the treatment. They should, however in my opinion be admitted, since the value of a series depends to a great extent upon its being composed of consecutive cases, while for purposes of comparison this is essential, for no data exist which enable us to appreciate the mortality under the ordinary treatment of cases whose temperature range is between 103° and 105°.

Including all cases then, his mortality would probably be under 5 per cent., a result which I think possible for anyone in private practice, if he would adopt this line of treatment.

Dr. Rabl's views as to the injurious effects of opiates in fever appear to me to be based upon some preconceived theory. They are at any rate quite opposed to the experience of this hospital, where they are invariably used to moderate severe diarrhoea, and not unfrequently to calm nervous apprehension in those few patients who have a great repugnance to the bath.

I am, Sir, yours, &c.,

F. E. HARE, M.B., Etc.,

Resident Medical Officer, Brisbane Hospital.

COMPOUND COMMINUTED FRACTURE OF FEMUR.

(To the Editor of the A. M. Gazette.)

DEAR SIR,—In reading the case of "Compound Comminuted Fracture of Femur after Gunshot Wound," by Dr. Salter, published in your issue of 15th Sept., I should like to make a few remarks.

While congratulating Dr. Salter on the successful result, so far, of his case, I would remark, firstly: On the 23rd he says, "the patient suffered great pain, and did not sleep although gr. xl of Chloral hydrate were given, and a little later on the patient gets m xl liq. opii sed. The maximum dose of the former drug being grs. xxx, and of the latter m xx. Now, I think, it is much safer practice instead of giving an overdose of any hypnotic or sedative to give a draught of say—

℞. Pot. Brom. Hyd. Chloral ʒi gr. xv. Liq. Opii Sed. m xv.

With perhaps the addition also of m xv of Hyoscyamus, in this way we avoid the risk of giving too strong a dose of any one drug, and yet have the combined action of a greater number, which often assist each other in attaining the object we aim at.

I am perfectly well aware that very much larger doses of Chloral hydrate can be tolerated under certain circumstances, but, in such cases as the above, would it not be much better to be on the safe side by using the formula I suggest, and have a much greater chance of relieving pain, and giving sleep. Secondly: The wound was washed out with 1 ℥ 1000 Perchloride of Mercury. This appears to me to have been unnecessarily strong, one in 2000, or even 4000, making a very reliable antiseptic lotion. Lastly: When patient last heard of, he says, "the wounds still discharge, and pieces of bone still come away."

Now the man may have been very robust, but what will tend to undermine a constitution more than a chronic suppurative discharge, and the fact of pieces of bone still coming away is strong evidence to my mind that the case was discharged a little prematurely, and nature left to do a greater share of the work of reparation than she will probably be able to accomplish.

Yours truly, F. W. MONSELL,

L.R.C.S. & L.K.Q.C.P.I.

Port Pirie, South Australia.

NOTE ON THE EFFECTS PRODUCED ON MAN BY SUBCUTANEOUS INJECTIONS OF A LIQUID OBTAINED FROM THE TESTICLES OF ANIMALS.

BY DR. BROWN-SEQUARD, F.R.S., &c.

(Reprinted from the "Lancet" of July 20, 1889.)

On the 1st of June last I made at the Société de Biologie de Paris a communication on the above subject, which was published in the *Comptes Rendus* of that Society on June 21st (No. 24). I will give here a summary of the facts and views contained in that paper and in two subsequent ones, adding to them some new points.

There is no need of describing at length the great effects produced on the organisation of man by castration, when it is made before the adult age. It is particularly well known that eunuchs are characterized by their general debility and their lack of intellectual and physical activity. There is no medical man who does not know also how much the mind and body of men (especially before the spermatic glands have acquired their full power, or when that power is declining in consequence of advanced age) are affected by sexual abuse or by masturbation. Besides, it is well-known that seminal losses, arising from any cause, produce a mental and physical debility which is in proportion to their frequency. These facts and many others have led to the generally admitted view that in the seminal fluid, as secreted by the testicles, a substance or several substances exist which, entering the blood by resorption, have a most essential use in giving strength to the nervous system and to other parts. But if what may be called spermatic anæmia leads to that conclusion, the opposite state, which can be named spermatic plethora, gives as strong a testimony in favour of that conclusion. It is known that well-organized men, especially from twenty to thirty-five years of age, who remain absolutely free from sexual intercourse or any other causes of expenditure of seminal fluid, are in a state of excitement, giving them a great, although abnormal, physical and mental activity. These two series of facts contribute to show what great dynamogenic power is possessed by some substance or substances which our blood owes to the testicles.

For a great many years I have believed that the weakness of old men depended on two causes—a natural series of organic changes and the gradually diminishing action of the spermatic glands. In 1869, in a course of lectures at the Paris Faculty of Medicine, discussing the influence possessed by several glands upon the nervous centres, I put forward the idea that if it were possible without danger to inject semen into the blood of old men, we should probably obtain manifestations of increased activity as regards the mental and the various physical powers. Led by this view, I made various experiments on animals at Nahant, near Boston, (United States), in 1875. In some of those experiments, made on a dozen male dogs, I tried vainly except in one case, to engraft certain parts or the whole body of young guinea-pigs. The success obtained in the exceptional case served to give me great hopes that by a less difficult process I should some day reach my aim. This I have now done. At the end of last year I made on two old male rabbits experiments which were repeated since on several others, with results leaving no doubt

as regards both the innocuity¹ of the process used and the good effects produced in all those animals. This having been ascertained, I resolved to make experiments on myself, which I thought would be far more decisive on man than on animals. The event has proved the correctness of that idea.

Leaving aside and for future researches the questions relating to the substance or substances which, being formed by the testicles, give power to the nervous centres and other parts, I have made use in subcutaneous injections, of a liquid containing a small quantity of water mixed with the three following parts: first, blood of the testicular veins;² secondly, semen, and thirdly, juice extracted from a testicle crushed immediately after it has been taken from a dog or guinea-pig. Wishing in all the injections made on myself to obtain the maximum of effects, I have employed as little water as I could. To the three kinds of substances I have just named I added distilled water in a quantity which never exceeded three or four times their volume. The crushing was always done after the addition of water. Then filtered through a paper filter, the liquid was of a reddish hue and rather opaque, while it was almost perfectly clear and transparent when Pasteur's filter was employed. For each injection I have used nearly one cubic centimetre of the filtered liquid. The animals employed were a strong and, according to all appearances, perfectly healthy dog (from two to three years old), and a number of very young or adult guinea-pigs. The experiments, so far, do not allow of a positive conclusion as regards the relative power of the liquid obtained from a dog and that drawn from guinea-pigs. All I can assert is that the two kinds of animals have given a liquid endowed with very great power. I have hitherto made ten subcutaneous injections of such a liquid—two in my left arm, all the others in my lower limbs—from May 15th to June 4th last. The first five injections were made on three succeeding days with a liquid obtained from a dog. In all the subsequent injections made on May 24th, 29th, and 30th, and June 4th, the liquid used came from guinea-pigs. When I employed liquids having passed through Pasteur's filter, the pains and other bad effects were somewhat less than when a paper filter was used.

Coming now to the favourable effects of these injections, I beg to be excused for speaking so much as I shall do of my own person. I hope it will easily be understood that, if my demonstration has any value—I will even say any significance—it is owing to the details concerning the state of my health, strength, and habits previously to my experiments, and to the effects they have produced.

I am seventy-two years old. My general strength, which has been considerable, has notably and gradually diminished during the last ten or twelve years. Before May 15 last, I was so weak that I was always compelled to sit down after half-an-hour's walk in the laboratory. Even when I remained seated all the time, or almost all the time, in the laboratory, I used to come out of it quite exhausted after three or four hours' experimental labour, and sometimes after only two hours. For

many years, on returning home in a carriage by six o'clock after several hours passed in the laboratory, I was so extremely tired that I invariably had to go to bed after having hastily taken a very small amount of food. Very frequently the exhaustion was so great that, although extremely sleepy, I could not for hours go to sleep, and I only slept very little, waking up exceedingly tired.³

The day after the first subcutaneous injection, and still more after the two succeeding ones, a radical change took place in me, and I had ample reason to say and to write that I had regained at least all the strength I possessed a good many years ago. Considerable laboratory work hardly tired me. To the great astonishment of my two principal assistants, Drs. D'Arsonval and Hénocque, and other persons, I was able to make experiments for several hours while standing up, feeling no need whatever to sit down. Still more: one day (the 23rd of May), after three hours and a quarter of hard experimental labour in the standing attitude, I went home so little tired that after dinner I was able to go to work and to write for an hour and a half a part of a paper on a difficult subject. For more than twenty years I had never been able to do as much.⁴ From a natural impetuosity, and also to avoid losing time, I had till I was sixty years old, the habit of ascending and descending stairs so rapidly that my movements were rather those of running than of walking. This had gradually changed, and I had come to move slowly up and down stairs, having to hold the banister in difficult staircases. After the second injection I found that I had fully regained my old powers, and returned to my previous habits in that respect.

My limbs, tested with a dynamometer, for a week before my trial and during the month following the first injection, showed a decided gain of strength. The average number of kilogrammes moved by the flexors of the right forearm, before the first injection, was about 34½ (from 32 to 37), and after that injection 41 (from 39 to 44), the gain being from 6 to 7 kilogrammes. In that respect the forearm flexors re-acquired, in a great measure, the strength they had when I was living in London (more than twenty-six years ago). The average number of kilogrammes moved by those muscles in London in 1863⁵ was 43 (40 to 46 kilogrammes).

I have measured comparatively, before and after the first injection, the jet of urine in similar circumstances—i.e., after a meal in which I had taken food and drink of the same kind in similar quantity. The average length of the jet during the ten days that preceded the first injection was inferior by at least one quarter of what it came to be during the twenty following days. It is therefore quite evident that the power of the spinal cord over the bladder was considerably increased.

One of the most troublesome miseries of advanced life consists in the diminution of the power of defæcation.

¹ I ought to say that, notwithstanding that dark picture, my general health is and has been almost always good, and that I had very little to complain of, excepting myalgia and muscular rheumatism.

² My friends know that, owing to certain circumstances and certain habits, I have for thirty or forty years gone to bed very early and done my writing work in the morning, beginning it generally between three and four o'clock. For a great many years I had lost all power of doing any serious mental work after dinner. Since my first subcutaneous injections I have very frequently been able to do such work for two, three, and one evening for nearly four hours.

³ I have a record of the strength of my forearm, begun in March 1860 when I first established myself in London. From that time to 1862 I occasionally moved as much as 50 kilogrammes. During the last three years the maximum moved was 38 kilogrammes. This year, previously to the first injection, the maximum was 37 kilogrammes. Since the injection it has been 44.

¹ This innocuity was also proved on a very old dog by twenty subcutaneous injections of a fluid similar to that I intended to employ on myself. No apparent harm resulted from these trials, which were made by my assistant, Dr. D'Arsonval.

² For reasons I have given in many lectures in 1869 and since, I consider the spermatic as also the principal glands (kidneys, liver, &c.,) as endowed, besides their secretory power with an influence over the composition of blood, such as is possessed by the spleen, the thyroid, &c. Led by that view, I have already made some trials with the blood returning from the testicles. But what I have seen is not sufficiently decisive to be mentioned here.

To avoid repeating the details I have elsewhere given in that respect, I will simply say that after the first days of my experiments I have had a greater improvement with regard to the expulsion of fecal matters than in any other function. In fact a radical change took place, and even on days of great constipation the power I long ago possessed had returned.

With regard to the facility of intellectual labour, which had diminished within the last few years, a return to my previous ordinary condition became quite manifest during and after the first two or three days of my experiments.

It is evident from these facts and from some others that all the functions depending on the power of action of the nervous centres, and especially of the spinal cord, were notably and rapidly improved by the injections I have used. The last of these injections was made on June 4th, about five weeks-and-a-half ago. I ceased making use of them for the purpose of ascertaining how long their good effects would last. For four weeks no marked change occurred, but gradually, although rapidly, from the third of this month (July) I have witnessed almost a complete return of the state of weakness which existed before the first injection. This loss of strength is an excellent counter-proof as regards the demonstration of the influence exerted on me by the subcutaneous injections of a spermatic fluid.

My first communication to the Paris Biological Society was made with the wish that other medical men advanced in life would make on themselves experiments similar to mine, so as to ascertain, as I then stated, if the effects I had observed depended or not on any special idiosyncrasy or on a kind of auto-suggestion without hypnotisation, due to the conviction which I had before experimenting that I should surely obtain a great part at least of these effects. This last supposition found some ground in many of the facts contained in the valuable and learned work of Dr. Hack Tuke on the "Influence of the Mind over the Body." Ready as I was to make on my own person experiments which, if they were not dangerous, were at least exceedingly painful, I refused absolutely to yield to the wishes of many people anxious to obtain the effects I had observed on myself. But, without asking my advice, Dr. Variot, a physician who believed that the subcutaneous injections of considerably diluted spermatic fluid⁶ could do no harm, has made a trial of that method on three old men—one fifty-four, another fifty-six, and the third sixty-eight years old.⁷ On each of them the effects have been found to be very nearly the same as those I have obtained on myself. Dr. Variot made use of the testicles of rabbits and guinea-pigs.

These facts clearly show that it was not to a peculiar idiosyncrasy of mine that the effects I have pointed out were due. As regards the explanation of those effects by an auto-suggestion, it is hardly possible to accept it in the case of the patients treated by Dr. Variot. They had no idea of what was being done; they knew nothing of my experiments, and were only told that they were receiving *fortifying* injections. To find out if this qualification had anything to do with the effects produced, Dr. Variot, since the publication of his paper, has employed similar words of encouragement, whilst

making subcutaneous injections of pure water on two other patients, who obtained thereby no strengthening effect whatever.⁸

I believe that, after the results of Dr. Variot's trials, it is hardly possible to explain the effects I have observed on myself otherwise than by admitting that the liquid injected possesses the power of increasing the strength of many parts of the human organism. I need hardly say that those effects cannot have been due to structural changes, and that they resulted only from nutritive modifications, perhaps in a very great measure from purely dynamical influences exerted by some of the principles contained in the injected fluid.

I have at present no fact to mention which might serve to solve the question whether it would be possible or not to change structurally muscles, nerves, and the nervous centres by making during a good many months frequent injections of the fluid I have used. As I stated at the Paris Biological Society, I have always feared, and I still fear, that the special nutritive actions which bring on certain changes in man and animals, from the primitive embryonal state till death by old age, are absolutely fatal and irreversible. But in the same way that we see muscles which have from disease undergone considerable structural alterations regain sometimes their normal organization, we may, I believe, see also some structural changes not essentially allied with old age, although accompanying it, disappear to such a degree as to allow tissues to recover the power they possessed at a much less advanced age.

Whatever may be thought of these speculations, the results I have obtained by experiments on myself and those which have been observed by Dr. Variot on three old men show that this important subject should be further investigated experimentally.⁹

Brighton.

BOOK NOTICES.

Examination of Water for Sanitary and Technical Purposes. By Henry Leffmann, M.D., Ph. D., Professor of Chemistry in the Woman's Medical College of Pennsylvania, etc., and William Beam, M.A., Demonstrator of Chemistry in the Pennsylvania College of Dental Surgery. 106 pages. Philadelphia: P. Blakiston, Son, and Co., 1889. Sydney: L. Bruck. Price, 4s. 6d.; by post, 4s. 9d. This handy little book treats first of the history of natural waters and then of analytical examinations, both sanitary and technical, with interpretation of the results. In the description of the general quantitative analysis the authors have followed to a large extent the methods indicated by Fresenius, selecting those best adapted to technical purposes, and in many of the sanitary examinations they have given the processes approved by the Society of Public

⁶In my third communication at the Biological Society, I said that both the intense pain each injection has caused me and the inflammation it has produced would be notably diminished if the liquid employed were more diluted. The three cases of Dr. Variot have proved the exactitude of my statement. He made use of a much larger amount of water and his patients had to suffer no very great pain and no inflammation.

⁷The paper of Dr. Variot and my remarks upon it have appeared in the *Comptes Rendus de la Société de Biologie*, No. 23, 5 Juillet 1889, pp. 451 and 454.

⁸Since writing the above I have received a letter from Dr. Variot announcing that, after injecting the liquid drawn from the testicles into these two individuals, he has obtained the same strengthening effects I have myself experienced.

⁹It may be well to add that there are good reasons to think that subcutaneous injections of a fluid obtained by crushing ovaries just extracted from young or adult animals, and mixed with a certain amount of water, would act on old women in a manner analogous to that of the solution extracted from the testicles of old men.

Analysts of Great Britain. A brief notice is given of the bacteriological examinations, and care has been taken to have the nomenclature and notation conform to the most advanced and precise systems in vogue; and to assist in precision in this respect a set of labels adapted to the reagents used accompanies the book. The work is sufficiently complete for its purpose, well written, concise and clear, and will be of good service to the sanitarian.

Epitome of Surgery: Being a Complete Compendium of the Science and Art of Surgery. By Ridley Dale, M.D., M.R.C.S.E. 498 pages. London: H. K. Lewis, 1889. Sydney: L. Bruck. Price, 10s. 6d.; by post, 11s. 8d. This work, being a synopsis of the most important points in surgery, is intended to serve the student as an aid to his memory when preparing for examination, and, though written primarily for the student, the work should also be of some service to the practising surgeon who may wish to refresh his memory on certain points, and for which purpose the book will afford a ready means of reference. The work is arranged in thirteen sections, embracing forty-three chapters, and forms a fair compendium of current opinion and practice within moderate space.

Lectures on Bright's Disease. By Robert Saundby, M.D. Ed., F.R.C.P. Lond., Emeritus Senior President of the Royal Medical Society, etc. 290 pages; fifty illustrations. Bristol: John Wright and Co., 1889. Sydney: L. Bruck. Price, 6s. 6d.; by post, 7s. The author of this volume, by talent, position, study, long experience and special attention to renal diseases, is amply qualified to present such a volume. The whole subject has been thoroughly investigated, the present state of contemporary knowledge on this disease is clearly stated, and additions and suggestions which have resulted from thirteen years clinical and pathological study of Bright's disease under the most favourable environments have been made. Its contents treats on: I. Albuminuria; Pathology of Dropsy; Polyuria; Uræmia; Cardio-Vascular, and Retinal Changes. II. Clinical Examinations and Tests of the Urine in Health and Disease. III. Bright's Disease, its History; Classification; Etiology; Anatomy of the Kidney; Febrile, Lithemic, and Obstructive Nephritis; Complications of Chronic Cases; Treatment. Such an exhaustive treatise within a modest compass by such a thoroughly competent author should be welcomed by the profession.

Text-Book of Medical Jurisprudence and Toxicology. By John J. Reese, M.D., Professor of Medical Jurisprudence and Toxicology in the

University of Pennsylvania, etc., etc. Second edition. Revised and enlarged. 646 pages. Philadelphia: P. Blakiston, Son, and Co., 1889. Sydney: L. Bruck. Price, 14s.; by post, 15s. The second edition of this excellent work has been carefully revised, and considerable new matter of importance added, especially in the chapters on blood stains, suffocation, ptomaines, and malpractice, also in various articles in the department of toxicology. Though the work is written principally as a text-book for students of legal medicine, in which branch Professor Reese has for over a quarter of a century occupied a prominent place as a teacher, yet as a complete manual of its kind it will be found useful and interesting by the general practitioner.

Masso-Therapeutics, or Massage as a Mode of Treatment. By William Murrell, M.D., F.R.C.P. Fourth edition. 236 pages; illustrated. London: H. K. Lewis, 1889. Sydney: L. Bruck. Price, 4s. 6d.; by post, 5s. This book is the result of extensive experience, and deals principally with the practical methods of massage, to enable the physician to carry out the treatment in his private practice. The author fully describes the method of performing massage, and its physiological action, showing that massage strengthens the muscles, gives tone to the nervous system, and increases the functional activity of all the organs of the body; it improves nutrition and thus the quantity and condition of the blood. Dr. Murrell dilates on its beneficial use in paralysis, in constipation, as a remedy for rheumatism, in neurasthenia, for spinal irritation, in organic diseases, surgical affections, poisoning and uterine complaints.

Exploration of the Chest in Health and Disease. By Stephen S. Burt, M.D., Professor of Clinical Medicine and Physical Diagnosis in the New York Post Graduate Medical School and Hospital; Physician to the Outdoor Department Bellevue Hospital. 206 pages; illustrated. New York: D. Appleton and Co., 1889. Sydney: L. Bruck. Price, 6s. 6d.; by post, 7s. The object of this little volume is to aid the student in his efforts to learn the significance of physical signs and their mode of development. In the construction of the book the author has utilized the results of his own personal experience, as well as the common stock of medical teaching. He gives considerable attention to the normal anatomy and physiology of the thoracic viscera, and then clearly indicates the morbid changes that give rise to abnormal physical signs. It is a well-written book, concise and yet comprehensive, and will be found very useful both by practitioners and students.

THE MONTH.

NEW SOUTH WALES.

MR. D. BERRY, who lately died at the age of 97 at Berry, made the munificent bequest of £100,000 for the erection and maintenance of a hospital at Berry, late Broughton Creek, for the benefit of the Shoalhaven district.

THE new hospital building at Goulburn was opened on October 11.

A NEW hospital is now being erected at Grenfell, at a cost of £1595.

A COTTAGE hospital is being erected at Junee.

THE foundation stone of a Cottage Hospital was laid at Jerilderie on October 5.

MR. JOHN EATON, L.A.H. Dub. 1835, died at Oberon on September 23; the deceased gentleman practised in the district for over 30 years.

DR. ROBERT BEITH, late Government Medical Officer in Fiji, has commenced practice at Pendower, Moonbie-street, Summerhill, a suburb of Sydney.

DR. H. M. GAY has been appointed Visiting Surgeon and Dispenser to the Dubbo Gaol, *vice* Dr. Warren, resigned.

DR. A. JARVIE HOOD, on leaving the Clarence River district for Sydney, was presented with a handsome silver tea and coffee service and an illuminated address by the residents of Maclean.

DR. H. W. JACKSON, who for many years past practised in Phillip-street, Sydney, has, through continued ill health, been compelled to retire from the active practice of his profession. His medical advisers attribute this failure of health to be due to some additional work which he undertook some two years ago.

DR. J. W. KENNEDY has been elected Mayor of Hay.

DR. F. MILFORD has resigned his office as Lecturer on Surgery at the Sydney University.

DR. J. F. NELLY, who for the last fifteen months held the position of resident surgeon at St. Vincent's Hospital, Sydney, was presented on leaving the institution early this month, with an address and a handsome travelling bag by the nurses connected with the hospital; Dr. Nelly has gone to Melbourne to take charge of the practice of Dr. Macinerney at Fitzroy, during the latter's absence in England.

DR. H. I. TRESIDDER, late of Coonamble, has succeeded to the practice of Dr. Warren at Dubbo.

DR. R. B. TRINDALL, a graduate of the Sydney University, has been appointed Medical Officer to attend the coal miners at Helensburgh, 29 miles S. of Sydney.

SURGEON-MAJOR W. D. C. WILLIAMS has been promoted to be Brigade Surgeon, ranking as Lieutenant Colonel, and to be principal Medical Officer to the military forces of the colony.

NEW ZEALAND.

AT Dunedin, on August 28th, the degree of M.B. of the New Zealand University was conferred on Messrs. G. A. Copeland, H. C. Barclay, and W. T. Dermer.

DR. P. A. LINDSAY has been appointed Honorary Surgeon to the New Zealand Artillery Volunteers, "O" Battery.

DR. W. G. MC LENNAN has settled at Masterton, 70 miles N.E. of Wellington.

DR. JOHN ROSS, late of Wetheral, Carlisle (Eng.), has settled at Wairoa (Clyde), 54 miles N.E. of Napier.

QUEENSLAND.

AT a recent Committee meeting of the Maytown district Hospital, Dr. E. M. Fitzgerald of Roma, was appointed surgeon in place of Dr. St. George Queely, resigned; Dr. Queely has left Maytown for Maryborough.

DR. VON LUKOWICZ, late of Cooktown, has succeeded to the practice of Dr. W. M. Fisher, at Cloncurry, 372 miles W. of Townsville.

DR. A. E. SALTER has been appointed Assistant Immigration Agent at Thursday Island.

SOUTH AUSTRALIA.

THE S.A. MEDICAL PRACTITIONERS' ASSOCIATION, at a meeting held on September 20, supported the Medical Board in its action in resigning owing to the Supreme Court granting a *mandamus* compelling the Board to register Dr. Geo. Bollen, who had obtained a diploma in Chicago. It was also decided to ask the Government for fresh legislation on the subject of qualification.

DR. E. HOCHER has settled at Port Germein, 172 miles N. of Adelaide.

DR. L. S. O'FLAHERTY, of Hindmarsh, Adelaide, has been appointed successor to Dr. P. M. Wood as Government Medical Officer at Palmerston, Port Darwin, Northern Territory.

VICTORIA.

A TEMPORARY retreat for inebriates is to be established by the Government at Beaconsfield. A house has been granted for the purpose pending the erection of a permanent building, which will be located at Cheltenham. At present accommodation is provided for 12 male patients, and another building is being sought to provide for a limited number of female patients. Mr. C. Williams, who has for years been in charge of a similar institution near Adelaide, has been appointed Superintendent.

THE ordinary monthly meeting of the Medical Society of Victoria was held in the hall of the society, Albert-street, East Melbourne on October 2, under the presidency of Dr. Balls-Headley. Dr. Gurdon, of Brighton, Dr. Kennedy, of Cobram, and Dr. O'Sullivan, of Yarrowonga, were elected members of the society. Dr. J. W. Barrett submitted a proposal for the uniform doses of all drugs. Dr. C. S. Ryan gave an account of two operations. Dr. Herman Lawrence related a method of treatment of bad complexion, and Mr. Syme exhibited some pathological specimens.

THE Committee of the Melbourne Hospital have adopted the recommendation by a sub-committee that a medical superintendent should be appointed at a salary of £500 a year, and that two registrars should be appointed—one for medical, and one for surgical cases—at a salary of £100 a year each.

WE learn that the medical examination of the pilots will in future be made by Dr. D. Grant, of Collins-street, Melbourne.

DR. W. Maloney, M.L.A., Dr. Willmott, Dr. E. J. Williams, and Dr. J. J. Miller acted as judges at the baby show held in the Melbourne Exhibition building early this month.

DR. G. P. ATKINS has removed from Hawthorn to Frankston, on the Eastern shores of Port Phillip Bay, 27 miles S.E. of Melbourne.

DR. CHARLES BROOM has removed from Toongabbie to Minyip, 227 miles N.W. of Melbourne.

DR. THOMAS CARR has commenced practice at 5 Howe Crescent, South Melbourne.

DR. E. HARKNESS has removed from Surrey Hills (Melbourne) to Avoca, 126 miles N.W. of Melbourne.

DR. W. E. LE FANU HEARN has resigned his position as surgeon and physician to the Hamilton Hospital, which he has held for six years. His resignation was accepted with many expressions of regret by the committee, and it was decided to present him with an illuminated address, testifying to his skill and attention. Dr. Hearn intends to commence practice in Melbourne.

DR. G. L. LAYCOCK, of Collins st. East, Melbourne, has been elected medical galvanist to the Prince Alfred Hospital.

DR. W. MOIR, has removed from Corack to Morwell, 89 miles E. of Melbourne.

DR. PINNOCK has been elected honorary surgeon, and Dr. Salmon honorary physician of the Ballarat Hospital.

DR. L. ROBINSON, late of Talbot, has been elected Resident Surgeon of the Hamilton Hospital, in the place of Dr. Hearn, resigned.

DR. THOS. WARREN has commenced practice at Echuca.

WESTERN AUSTRALIA.

DR. H. F. HARVEY, late of Auburn, S.A., is now practising at Bunbury, 112 miles south of Perth. Dr. Harvey is acting as Resident Medical Officer at Bunbury during the temporary absence on leave of Dr. J. T. Laffan.

PROCEEDINGS OF COLONIAL MEDICAL BOARDS.

The following gentlemen, having presented their diplomas, have been duly registered as legally qualified Medical Practitioners, by the respective Boards:—

NEW SOUTH WALES.

Beith, Robert, M.B. & Ch.M. Glasg., 1882.
Strangman, Thomas Handcock, L. & L. Mid. K.Q.C.P. Irel., 1886; L.R.C.S. Irel., 1886.
Theod, Stanley Vipan, L.R.C.P. Edin., 1880; M.R.C.S. Eng., 1880.
Linton, Edward, L.R.C.P. Edin., 1887; L.F.P.S. Glasg., 1887; L.R.C.S. Edin., 1887.
Kearwood, Harry Richard, M.B. Edin., 1887; L.R.C.P. Lond., 1888
O.M. Edin., 1887.

For additional Registration:

Tarrant, Harman John, F.R.C.S. Edin., 1887.
Mellins, George Lane, M.D. Trin. Coll. Dub., 1888; L. Mid. K.Q.C.P. Irel., 1888.

NEW ZEALAND.

Ross, John, M.B. & Ch.M. Edin., 1886.

VICTORIA.

Shiels, Edward Bedale, L. & L. Mid. R.C.P. & R.C.S. Edin., 1888.
Carr, Thomas, L. & L. Mid. K.Q.C.P. Irel., 1887; L.R.C.S. Irel., 1888.
Finmore, James Harman, L.S.A. Lond., 1878; L. & L. Mid. R.C.P. Edin., 1874.

WE have been requested to call the attention of our readers to the advertisement in another place relating to the Heretaunga school for boys at Hastings, New Zealand. All the local medical men speak in the highest terms of both the Principal and Master, and in every way recommend the school.

MEDICAL APPOINTMENTS.

Atkins, George Purcell, L.K.Q.C.P. Irel.; L.R.C.P. & R.C.S. Edin. to be Public Vaccinator at Frankston, Vic.
Broom, Charles, M.R.C.S. Eng., to be Health Officer for the Minyip District, Vic., vice Dr. A. Grant, resigned.
Gay, Herbert Moutrie, M.B. & Ch.M. Glasg., to be Government Medical Officer and Vaccinator for the District of Dubbo, N.S.W., vice Dr. H. G. S. Warren, resigned.
Harkness, Edward, L.R.C.P. & R.C.S. Ed.; L.F.P.S. Glasg., to be Public Vaccinator at Avoca, Vic., vice Dr. J. McMahon, resigned.
Hoche, Edward, M.D., to be Public Vaccinator for the District of Port Germain, S.A.
Keyes, Francis Joseph, M.D. & Ch. M. Roy. Univ. Irel., to be Public Vaccinator at Nathalia, Vic.
Lukowicz, Maximilian Carl Marcell von, M.D., to be Government Medical Officer at Olonourry, Oz., vice Dr. Fisher, resigned.
McHenry, James Joseph, L.R.C.P. & R.C.S. Edin.; L.F.P.S. Glasg., to be Health Officer for the West Chariton District, Vic.
McLennan, Warwick Guy, L.R.C.P. Ed.; M.R.C.S. Ed., to be an additional Public Vaccinator for the District of Masterton, N.Z.
Maller, Melrose, M.B. & Ch.B. Melb., to be Public Vaccinator at Carlton North, Vic.
Moir, William, M.B. & Ch.M. Aberd., to be Public Vaccinator at Morwell, Vic.
Nagel, Günther, M.D., to be Government Medical Officer and Vaccinator for the District of Singara, N.S.W.
Norris, William Ferrin, M.B. Melb., to be Public Vaccinator at Coalville, Vic.
Robinson, Archibald Clarke, M.D., L.R.C.S. Ed., to be Government Medical Officer and Vaccinator for the District of Jerilderie, N.S.W.
Taylor, George Henry, L.R.C.P. & R.C.S. Ed., to be Resident Medical Officer at the Hospital for the Insane, Parramatta, N.S.W.

BIRTHS, MARRIAGES, AND DEATHS.

*• The charge for inserting announcements of Births, Marriages, and Deaths is 2s. 6d., which should be forwarded in stamps with the announcement.

BIRTHS.

FAITHFULL.—October 4, at 5 Lyons Terrace, Sydney, the wife of Dr. R. L. Faithfull, of a son.
GOODE.—August 19, at Macquarie street, Sydney, the wife of William H. Goode, M.D., of a son.
MACKELLAR.—September 29, at Rose Bay, near Sydney, the wife of Charles K. Mackellar, M.B., of a son.
SOOT-SKIRVING.—September 7, at Elizabeth street, Hyde Park, Sydney, the wife of Dr. R. Soot-Skirving, of a son.

MARRIAGES.

BRUCK-SMYTH.—September 19, at Glebe Point, Sydney, by the Rev. R. S. Paterson, Ludwig Bruck, Medical Publisher, to Emmeline H. S., youngest daughter of the late Henry William Smyth, Dublin.
CUMMINGS-HIGGINS.—September 4, at St. Mary's, Waverley, Sydney, Harold Lytton Cummings, M.R.C.S., L.R.C.P. Lond. to Marcia, eldest daughter of R. M. Higgins, Braidwood, N.S.W.
PENNY-COADE.—On the 16th September, at St. Mark's church, Albion (Brisbane), John A. Cairns Penny, L.R.C.S. Irel., L.K.Q.C.P.I., to Frances Margaret, second daughter of the late James Coad, of Ranelagh, Ireland.

DEATHS.

OUSCADEN.—On the 5th September, at Port Melbourne, Dorothea, only daughter of George Ouscaden, surgeon, aged five months and fourteen days.
SOUTER.—September 4, at Hillston, New South Wales, the wife of Dr. C. H. Souter, of septicaemia.

MEDICAL Practice for immediate disposal. Vendor going to England. Last year's cash receipts, £529. Price, £100, to include drugs and furniture. Apply to "Surgeon," care L. Bruck, 35 Castlereagh-street.

BOWREAL.—Dr. Wilson has superior accommodation for medical boarders.

REPORTED MORTALITY FOR THE MONTH OF AUGUST, 1889.

Cities and Districts.	Population.	Births Registered.	Deaths Registered.	Deaths under Five Years.	Number of Deaths from									
					Measles.	Scarlet Fever.	Group and Diphtheria.	Whooping Cough.	Typhoid Fever.	Dysentery and Diarrhoea.	Phthisis.	Heart Disease.	Cancer.	Child-bearing.
N. S. WALES.														
Sydney	132,846	282	184	42	...	...	1	2	1	1	17	12	2	2
Suburbs	215,849	808	245	98	...	1	22	4	1	2	24	15	8	6
NEW ZEALAND.														
Auckland	35,858	65	25	10	...	...	...	...	...	...	2	2	...	...
Christchurch	16,455	36	9	1	...	...	1	...	...	...	1	1	...	...
Dunedin	23,546	38	18	5	...	...	1	...	...	...	4	...	...	...
Wellington	29,075	85	25	9	...	...	1	...	3	1	1	...	...	...
QUEENSLAND.														
Brisbane	51,689	211	62	16	} ...	...	4	1	4	4	9	7	7	2
Suburbs	21,960	153	89	23										
SOUTH AUSTRALIA.														
Adelaide	312,813	...	...	...	...	...	...	...	...	...	...	...	...	...
Adelaide	48,750	...	...	...	...	...	...	...	...	...	...	...	...	...
TASMANIA.														
Hobart	35,113	90	58	8	...	1	4	...	5	...	6	7	1	...
Launceston	21,418	67	42	8	...	...	3	...	2	...	3	3	...	...
Country Districts	91,780	304	60	...	...	...	2	...	1	1	...	...	...	...
VICTORIA.														
Melbourne	75,400	125	105	} 258	...	3	41	19	16	6	73	58	24	6
Suburbs	362,385	1353	608											

METEOROLOGICAL OBSERVATIONS FOR AUGUST, 1889.

STATIONS.	THERMOMETER.					Mean Height of Barometer.	RAIN.		Mean Humidity.	Prevailing Wind.
	Maximum Sun.	Maximum Shade.	Mean Shade.	Minimum Shade.			Depth.	Days.		
							Inches			
Adelaide—Lat. 34° 55' 33" S.; Long. 138° 36' E. ....	...	...	...	...	...	...	...	...	...	...
Auckland—Lat. 36° 50' 1" S.; Long. 174° 49' 2" E.	133°	62°5	52°2	40°	...	...	2°590	18	80	...
Brisbane—Lat. 27° 28' 3" S.; Long. 153° 16' 15" E.	124°2	78°6	60°5	41°5	30°125	...	3°832	12	69	s.
Christchurch—Lat. 43° 32' 16" S.; Long. 172° 38' 59" E.	120°	66°	43°7	26°6	...	...	0°983	9	78	...
Dunedin—Lat. 45° 52' 11" S.; Long. 170° 31' 11" E.	105°	55°	42°6	31°	...	...	1°322	12	78	...
Hobart—Lat. 42° 53' 32" S.; Long. 147° 22' 20" E. ....	...	66°8	48°4	32°2	29°976	...	0°96	18	79	...
Launceston—Lat. 41° 30' S.; Long. 147° 14' E. ....	...	62°2	48°1	31°2	30°057	...	3°74	12	83	...
Melbourne—Lat. 37° 49' 54" S.; Long. 144° 58' 42" E. ....	...	68°	50°1	32°1	30°020	...	2°06	15	...	...
Sydney—Lat. 33° 51' 41" S.; Long. 151° 11' 49" E. ....	...	69°7	54°7	42°2	30°143	...	4°11	18	79	w.
Wellington—Lat. 41° 16' 25" S.; Long. 174° 47' 25" E.	110°	62°	48°8	35°	...	...	2°590	15	75	...

AUSTRALASIAN MEDICAL GAZETTE.

ORIGINAL ARTICLES.

NOTES OF SOME RECENT CASES OF INTESTINAL SURGERY.

READ BEFORE THE NEW SOUTH WALES BRANCH,
BRITISH MEDICAL ASSOCIATION.

By G. E. TWYNAM, L.B.C.P., LOND., M.R.C.S.E.,
HON. SURGEON, PRINCE ALFRED HOSPITAL,
SYDNEY.

I have chosen to-night to bring before you a group of cases rather than to report any case in particular; not but what, I trust, you may think that some of them would have deserved separate treatment, but rather with the idea of taking a comprehensive view of a certain portion of the large field which intestinal surgery, strictly speaking, presents to us.

I have purposely excluded hernia appearing externally in all its forms, as well as cases of intestinal injury, and have confined my notes to cases of *intestinal obstruction* which have come before me in the last fifteen months.

As a rule, where the peritoneum has been handled I have used water that has been boiled with or without boracic acid to wash out the cavity, catgut ligatures, carbolised silk that has been boiled for sutures, and sal-alembroth or salicylic wool as a dressing; the spray has not been used in any case. I have not stitched the peritoneum separately, although in some cases it might be advisable.

The subject of bowel obstruction is one of so frequent occurrence and of such paramount importance that it is necessary to keep it constantly before us, and as it has been my lot to meet with a very varied assortment, it may be worth while to review them.

Amongst them I have included two cases of inflammation of the vermiform appendix, as the symptoms so closely resemble those of obstructed bowel.

Cases of obstruction of the bowels fall naturally into two great divisions, namely, acute and chronic. I shall take the acute first.

The causes of acute obstruction are:—

Firstly: Internal hernia, owing to the gut slipping through a hole in the mesentery or omentum, or being nipped by bands or adhesions, or, lastly, by a Meckel's diverticulum.

Secondly: Intussusception.

Thirdly: Volvulus.

Fourthly: Stricture, gradually closing and being suddenly occluded.

Fifthly: Spasmodic contraction of bowel.

The symptoms come on early, and are very marked in most of these, great depression, constipation without passage of flatus, vomiting rapidly becoming stercoraceous, usually intense pain at one spot; tympanites with rapid swelling of abdomen—in one form the bowels may frequently be seen rolling about, in another a clearly marked swelling may be felt.

The first case I shall bring before you is one which really falls under the heading of the fourth form, though very closely allied to the first.

A. P., aged 28. A healthy man, but previously injured in the Peat's Ferry accident. First consulted Dr. MacSwinney on May 10th, to whom I am much indebted for the following history:—

He complained of severe abdominal pain and vomiting, and could keep nothing on his stomach; had taken pills two days before, as he did not feel well. The complexion was sallow, and he appeared to be suffering from a bad bilious attack. He was ordered calomel and jalap, which did not act, and next day he seemed worse. The pain being so severe, morphia (a sixth of a grain) was ordered every two hours. On the twelfth he was much better, vomiting ceased, and bowels relieved by enema.

13th. Much worse, vomiting and pain incessant; bowels relieved by enema; says he had a similar attack two years previously, but got better sooner. The vomit at first was clear and frothy, now it is greenish.

14th, 15th, 16th, and 17th. Condition much the same, only relieved from pain and retching by morphia; bowels acted, and flatus passed after enema.

May 18th. Temperature has never reached 100, and pulse is still good; the vomit to-day is different from anything previously thrown up—now very offensive; in the afternoon it was distinctly faecal. Patient agreed to operation if necessary, and I was sent for.

On my arrival I found the patient with a drawn, anxious look; pulse fair; had vomited constantly throughout the day, its character being distinctly faecal. Complained of pain chiefly in the right iliac region; said he had not passed flatus except after enema; abdomen somewhat distended, but more especially on the left side and in front, whilst the bowels could be seen moving about; the neighbourhood of the caecum was not so distended, whilst the rectum was collapsed; no special pain around the vermiform appendix; resonance, on percussion, was very clear to a point near the caecum, whilst over that part it was not so clear. Taking the whole case into consideration we concluded there was an obstruction, which had gradu-

ally become more complete, and that it was probably due to a volvulus or band, and operation was decided on. At 10-30 p.m. I opened the abdomen by a median incision, and very soon felt with my finger where the bowel was collapsed towards the right iliac fossa, as I had expected. I next made out a band, tying the bowel down, and by holding the bowels aside we could see it. I passed an aneurism needle under, and cut out a portion between two ligatures; the bowel at once sprang up, and I thought the operation was completed. Dr. MacSwinney, however, suggested my feeling whether there was any other adhesion; I found that another portion of the bowel was tied down by another band immediately under the first, and much more tightly. With great difficulty I worked the aneurism needle under this band, but it was so short that I had only just room to divide between the ligatures. This portion then sprang up likewise. We washed out the abdomen with boiled water, but had to sew up rapidly as his pulse was failing. He was put back to bed, and his bowels acted in three hours.

Nothing was given by the mouth for twenty-four hours except ice, and then only Brand's essence, but nutrient suppositories were given by the rectum. Afterwards he had a good deal of suppuration in the line of the sutures, but eventually recovered completely without having had any alarming symptoms. I think the moral of this case is always to satisfy oneself that there is not a second obstruction.

The second case is one of intussusception which was brought to the hospital for operation.

J. H., aged 7, had an attack of diarrhoea on Friday night which continued during Saturday and Sunday.

During Sunday night the pain became very severe, with great straining, and the passing of mucus and blood. On examination an elongated swelling could be detected in the left lumbar and hypogastric region; but nothing could be felt through the rectum, vomiting, however, had come on, but never became really stercoraceous. The condition was at once suspected by Dr. H. Browne, and the case was seen in consultation on Monday night and again on Tuesday morning, after which the child was removed to hospital for operation, where I happened to be at the time of his arrival.

On admission his pulse was fair and surface warm. One half the abdomen was flattened, the other distended, and a clearly defined tumour could be felt on the left side.

After consultation considering the length of time from the probable commencement of the intussusception, namely thirty-four hours, it was decided not to wait to try distension of the lower bowel by air or water, which requires four or five

hours to elapse to be sure of the success or failure of this method.

With the kind assistance of Dr. Knaggs, I opened the abdomen in the middle line and made sure of the condition present directly, but could not draw out the bowel without extending my incision above the umbilicus; having done this, I drew out the descending colon, when the lower portion of the transverse colon was found intussuscepted into the descending for six or eight inches. Single-handed I could not withdraw it, but by Dr. Knaggs drawing on the upper portion whilst I compressed the tumour with my right hand as in taxis, and used my left forefinger to ease the ring where the intussusception commenced, it began to unravel; this was followed by a gush of fluid, after which with some difficulty the intussusception was withdrawn.

Curiously enough, a Meckel's diverticulum was noticed, but I decided not to remove it. The long abdominal wound, requiring fourteen stitches, was then sewn up after a good deal of trouble to prevent nipping a portion of the bowel by suture, a small fact, but one which has spoilt some operations; symptoms continuing though the place of obstruction has changed. The boy's bowels acted whilst he was still on the table.

Nothing but ice was given by the mouth, nutrient suppositories being given instead for three days with injections of warm water to relieve thirst, and opium to keep the bowels quiet. On the fourth day some Brand's essence was given; bowels acted naturally on the third, fourth and fifth days, temperature rose to 101.4 on two occasions when stitches required removal.

Arrowroot was allowed on the tenth day, and he was allowed to sit up on the eighteenth and was discharged on September 1st, twenty-six days from admission.

At the present time he is quite well and going to school, and there is no sign of yielding in the long cicatrix.

The consideration of this case raises two questions. (1.) How long in cases of suspected, as well as diagnosed, cases of intussusception are we justified in trying distension of the lower bowel: inversion of the patient, &c.

I can hardly believe that distension would have overcome the difficulty in this case, which was of thirty-four hours duration, because the pressure I found it necessary to use, and this period may be taken as some guide. If I had waited the usual four or six hours I fancy the swelling would have been so great that I should not have succeeded in reduction even with an operation; and this leads me to the second question, what is the best line of treatment, supposing reduction after abdominal section is unsuccessful?

In the light of the admirable paper of T. B. Jessett in the *B. M. J.*, July 27th last, I suppose, by many who have read that paper, it will be said that ileocolostomy would be the proper course under these circumstances. Could we be sure of the intussusception retaining its vitality I think it would be justifiable treatment, although it is a procedure that at the present moment can only be said to be *sub judice*.

Supposing, however, that after simple ileocolostomy the intussusception does slough, there must be great risk from peritonitis in consequence of the upper end of the lower bowel being imperfectly closed owing to the ulcerative process extending through the stitches.

In a similar case to mine, only with the difference that reduction is impossible, should the whole portion be removed for fear of such sloughing; I can see it would have been very difficult in this case to approximate the divided ends, from the situation of the intussusception, the one end being the transverse colon, and the other the sigmoid flexure or rectum.

None of the experimental cases reported give us any clue to this condition. Mr. Jessett suggests, it is true, that the intussusception might be removed through the wound in the lower bowel, but this is the difficulty to decide, where to open the bowel below, to allow of such removal unless the whole intussusception be removed, which means, probably, a large resection of bowel, necessarily prolonging the operation very much, and increasing the risk. On the other hand, if the intussusception be left I quite see that the cross-section of the bowel above would almost certainly put a stop to peristaltic action, and so prevent the bowel becoming more invaginated. However, Mr. F. Treves says, that "it is only by excising the involved segment that these evils can be obviated;" consequently, I take it, that in the future, the right course would be to excise the involved segment in spite of prolonging the operation—so doing what Mr. Jessett terms ileocolostomy with resection of the diseased portion.

The alternative operation is by invaginating both cut ends of the bowel and bringing them together by approximation plates after excision.

I think this will be the line of treatment modern surgery will take by those who have practised these operations in the place of the old plan of artificial anus or resection, with Zerny-Lembert sutures. I am sure supporters will be found for the older plan as the operation is more easily done, but the risk is much greater, as shown by a mortality of 86.6, in Mr. Curtis' collected cases, and 82.2 in Mr. A. E. Barker's collection.

These operations require practice, especially enterorrhaphy, which I do not think will ever get many supporters.

It seems to me that this is the relative position of the two cases of inflammation of the vermiform appendix noted above.

Whether they be looked upon as an instance of the 5th form, namely, spasmodic obstruction or as a paralysis of the bowel, the symptoms closely resemble those of acute obstruction, with the additional fact that the temperature rises rapidly, usually on the second or third day—reaching 102°.

The first case of this form which I bring forward is of great clinical importance.

A. L., a well-developed girl, spent the evening at her mother's house on Sunday, when she seemed quite well. She returned that night to the house where she was in service, and on Monday morning complained of pains in the abdomen and vomited. Thinking it was a bilious attack she took medicine, but did not return home until Tuesday, when she was very ill. She was seen by Dr. Ellis, who, suspecting the condition, asked me to meet him in consultation at once, which I did. When seen she had temperature above 102°; great pain in the right iliac fossa; constipation: offensive vomit, with chilly surface; she said no flatus passed except a little at the moment of vomiting, a fact I have noticed some few times now associated with this condition. We decided on her removal to hospital for immediate operation. The journey to the hospital caused her great pain, though taken in a landau carriage, extended on a bed. On examination, under chloroform, there was hardly any thickening to be detected in the neighbourhood of the appendix, but, from the localised character of the pain, I felt justified in cutting down to make free exit for pus if any were present.

A little urine drawn off was found, on boiling, to consolidate, and numerous casts were seen under the microscope. This decided me not to operate. She lingered two days and died of septic peritonitis.

The second case is that of a lad, J. R., aged 7 years, whom I saw in consultation with Dr. Bowker, who has kindly sent me the following history: The attack began with vomiting and severe pain across the whole stomach on November 8th. When first seen, Nov. 11th, pulse 160, temp. 101, in great pain. Nov. 12th, pulse, 180, temp. 98.8; evening ditto, pain in paroxysms. 18th, pulse 120, temp. 99, child evidently very ill, indeed, pain constant. 14th, I saw him in consultation, child nearly moribund, face drawn, vomiting offensive-smelling material; a firm, brawny swelling in the right hypogastric region

which pitted on pressure, and could be felt per rectum. The whole abdomen very swollen, respiration short and catchy. We decided the boy's only hope lay in a laparotomy. Whilst I was getting some instruments the bowel acted slightly with a bloody slime.

Dr. Bowker gave him a whiff of chloroform, and I cut along Bryant's line for the appendix, and exposed the cæcum without striking pus. However I thought I detected a bead in the lower angle of the wound, followed it up and opened the peritoneum just in front of the cæcum, which was followed by a gush of foul pus, and I put my finger into a localised peritonitic cavity. I purposely did not feel about and disturb the parts, but contented myself with gently washing out the cavity with boracic acid and inserting a large drainage tube. This gave the boy relief, but for a long time we thought he would not pull through. However, he did in about six weeks' time, and is now a healthy lad, though he has since had three slight attacks of pain in that region.

Now the points I wish to draw attention to in these cases are these:—1. As a help in diagnosis the passing of flatus during the act of vomiting, which is no doubt caused by the straining, forcing wind past the paralysed or spasmodically contracted portion of the gut. 2. In the first case I consider her removal to have been injurious, and for my own part in another case would prefer to run the risk of an operation in a cottage to repeating such removal. 3. The presence of albumen in marked quantity with casts. At the time I thought that did not justify any operation, but Dr. Wilson kindly made a special examination of the kidneys, and his report is as follows:—No catarrh; slight congestion; very slight granular swelling of tubular epithelium. Thus shewing that albumen, even in marked quantity, in persons believed to be previously healthy is not to be considered a bar to operation in cases of intestinal obstruction.

I now come to the cases of chronic obstruction, of which the causes are:—1. Fæcal impaction. 2. Compression of rectum by pelvic tumour. 3. Stricture of the large intestine.

The symptoms of this condition are usually much less acute, and generally the most marked symptom is progressive difficulty in defæcation; the motions are small and flattened or nearly fluid with, in general localized pain and straining, vomiting if present is rarely or never truly fæcal.

Of the first form, fæcal impaction, I had one case in February with distinct localised tumour in the left loin. The aspirating needle brought nothing but had a fæcal smell. Large oil enemata brought away some motion which was

followed by a kind of dysenteric diarrhoea, and the tumour disappeared but recurred after he left the hospital. However, I may be allowed to recall a case of Dr. Worrall's, lately recorded as an instance of this condition.

Of the second form my instance is that of a man aged 45 years who came into hospital complaining of pain and difficulty in defæcation and micturition. On examination a large tumour was felt occupying the whole prostate and extending on one side to the iliac spine.

He was sent out as incurable, but, having overheard me propose an operation, after he left, being in such intense agony, he begged me to do anything, although told he would probably die under the operation. He accepted that, and accordingly I operated by a right lateral lithotomy incision and scooped out the whole prostate and as much of the growth as I could reach, leaving his urethra as a cylinder running through the cavity; the wall of the rectum was left intact. This relieved both the rectum and the bladder for about six weeks, after which it recurred, and he eventually died exhausted from pain and hæmorrhage, which did not take place until the wound had closed to the size of a quill and he had been up and walking about.

Of the third form, malignant stricture, I have operated on two cases by Littre's old operation, and here let me give my decided preference to that in place of lumbar colotomy, for although the primary risk is somewhat greater it is more easily performed—the bowel being drawn out without difficulty, the operation being antiseptic, whilst the convenience to the patient afterwards is an immense consideration.

M. L., 42 years of age, had suffered severely from syphilis, and for the last eight years had had increasing difficulty in defæcation with discharge of blood, and was never able to go without a diaper.

The rectum was a hard cord from the anus as high as the sigmoid flexure, and would not admit the tip of the little finger until dilated, and then the bowel was found to be ulcerated as far as could be reached. Attempts were made to dilate with bougies, but the pain was so great that she ceased attending for some time; afterwards she returned, but with a recto-vaginal fistula and a quantity of thin foul discharge. I then advised operation. Accordingly I opened the abdomen by Littre's method, drawing the bowel well forward and stitching the two peritoneal surfaces together, also fixing the bowel to the flesh wound.

On the 5th day the adhesion was found to be very firm, accordingly the bowel was opened by making two incisions about an inch-and-a-half apart, across the protruded intestine and then

clamping the intervening portion with two pairs of long polypus forceps, the intermediate part of the gut was cut out to prevent too great shrinkage of the opening. I recommend this to any one doing this operation, as bleeding is very smart when the wound is made in the length of the bowel across the vessels. Everything seemed doing capitally, and the bowels were relieved several times, but she complained of great distension and desire to empty the bowels, not having had proper relief for so long. On the 8th morning I ordered half-an-ounce of castor oil which was given. The night previously she had been sitting up in bed knitting and talking. In an hour after taking the oil she complained of great pain; the bowels acted very freely by the wound, but she collapsed and died in five hours from that time. My idea is that the oil forced some feces past the wound, and the diseased bowel below gave way as the wound itself was perfect.

The inference to be drawn from this case is to allow the bowels to act naturally, when the bowel below is so diseased because one cannot prevent some feces passing the spur at first.

The second case is that of a man aged 32, admitted to the P.A.H. 10 weeks previously. He had had an attack of diarrhoea, at first with slime but no blood, latterly with nearly pure blood. After treatment outside he was told he had a stricture of the bowel, and advised to come to the hospital. On admission a hard irregular mass was to be felt high up in the rectum completely encircling the bowel, ulcerated and feeling very like an intussusception with a central dimple. On March 20th I operated by Littre's method, first fixing the peritoneum to the skin all round and then attaching the gut to the abdominal wall. The bowel was not opened until the 26th, when I opened it in precisely similar manner to the previous case. The feces did not pass well this way for some time, the greater part being still passed per rectum, but by the time he left the hospital most were passing through the wound.

The stricture proved to be a rapidly growing new growth, and increased very much in size whilst he remained in the hospital. During his stay he complained of great dragging from the spine and was in constant pain from that cause. Since he left we have heard that nearly all the feces are passing by the wound, and he says he is a good deal better, but the pain in the back is still severe at times, probably caused by the mesentery being involved in and dragged on by the new growth.

One difficulty I have found in these cases is, as this record shows, in making the spur sufficiently complete to prevent feces passing

beyond the opening, and for the future I shall draw the bowel as far out of the wound as possible, until the mesentery is tense, and then attach the lowest part by stitches placed close to the mesentery to the lower angle of the wound with the idea of closing as completely as possible the bowel below. This is a difficulty in my experience common to both inguinal and lumbar colotomy.

The protrusion of the mucus membrane which has been urged as a difficulty in both operations is, I think, partly prevented by removing the intervening portion of the gut as a firm cicatricial ring is formed large enough for feces to pass, whilst some of the mucus membrane is removed just where the greatest tendency to eversion takes place. My own feeling is that it is desirable to remove quite a third if not more of the circumference of the bowel in this manner.

To sum up these various conditions, I hope at least that we may be able to draw one inference from the cases presenting symptoms of acute obstruction. The first point seems to me to be *what should be our first indication that an operation is necessary?* And I think the real danger signal is *fecal vomiting*, and I would say in dealing with cases of obstruction, see all the vomited matter yourself, do not trust to anybody's account of them, have them kept that you may judge for yourself.

As soon as that particular odour and colour is perceptible make up your mind whether to advise operation at once and for all; for I ask how many are there amongst us who can truly say to ourselves, I wish I had not operated? but alas, how many—myself among the number—bitterly regret having postponed operation until too late, for I may remind you that the one hour's extra delay may allow the band to cut so deeply into the bowel that that bowel may be paralysed never to recover, and though an operation may be done however skilfully after, failure is the necessary result, the symptoms continuing.

It may be urged that the difficulty often lies in the question of peritonitis. How often is peritonitis simple? How many cases die as we say of peritonitis, in which we have no post-mortem, and are not sure that some obstruction may not have been present. With the modern treatment of peritonitis—both simple septic, and tubercular—has not washing-out the abdomen been justifiable treatment? In no condition, I take it, can the old saying that "Procrastination is the thief of time," be more truly applied than in this. It is postponing operation until too late that brings odium in the public mind on operations and operators. I am not aware that in the treatment of intussusception,

section of the constricting ring in the length of the gut, has been tried, would it not, probably, be a method of minimising the risk, the wound being stitched-up after? I think, at least, it might be done before excising, as it would make no difference if that were found necessary. In conclusion I wish to thank all those who supplied me with notes for their kind help.

I have here some specimens prepared according to Mr. Jessett's paper—bone plates, bowel united by approximation plates, enterorrhaphy and ileocolostomy.

Bone plates, indiarubber ring, wooden plate of absolute measurement, buried quilt suture.

After practising these operations I have ventured to epitomise the various methods proposed by Mr. Jessett, as there seems some difficulty in following them.

Gastroenterostomy by Approximation Plates.—

Draw out the stomach and jejunum, fixing the part to be operated on between indiarubber ligatures. Incise the upper or convex surface of jejunum for one inch; insert the bone-plate, the end ligatures hanging out of the wound. Pass the two lateral stitches through the gut a quarter-of-an-inch from the edge of the wound, opposite the middle of the incision, but leave two inches of the wound without stitching at all. Fix the plate into the stomach in the same manner. To finish off—Tie the lower lateral sutures together first, then the end sutures, and, finally, the top lateral, and put in a Lambert stitch or two to prevent tilting. This method can be used for any portion of the bowel by merely closing the cut ends first, before inserting the plates.

Circular Enterorrhaphy.—This is a troublesome operation, and not clear in his account. I believe it to be as follows: Fix the parts to be operated on as above. Cut out a V-shaped piece, and stop bleeding; line the end of the upper portion with an indiarubber ring by securing it with catgut to the edge of bowel. Have ready two sutures 20in. long, threaded with sewing needles at both ends. Taking one suture, pass the needles through from within out near the upper edge of the indiarubber ring one on either side of the mesentery.

The other suture is passed in the same way, at even distances on the convex surface of the bowel.

Next draw up the lower bowel and pass each needle through the serous and muscular coats of the corresponding parts of the lower portion by a Zerny-Lambert stitch, at least half-an-inch from the cut edge. Now draw on the threads which partly invaginate the edge of the lower bowel, as it is drawn over the indiarubber ring in the upper piece. A little help turns in the edge exactly as in an intussusception.

Separating the mesentery off for three-quarters-of-an-inch and sewing the peritoneum together over the portion of the bowel left denuded by this proceeding makes the invagination much easier. This is a very important point.

We are told next to tie off the sutures, and this is where the directions are not quite clear. If tied one to the other to make a sort of Greek pattern, they pucker the gut—as you can see in this specimen if the indiarubber ring is not pretty stout—which seems to me to be the important point. After this put in three Zerny-Lambert stitches in the circumference of the gut, between these stitches, and also one on either side of the mesentery. Now stitch up the mesentery, and then apply an omental flap by two stitches right through both surfaces of the flap and the mesentery, in the length of the mesentery parallel to the vessels.

Ileo-Colostomy.—This, though very similar to the above, is much easier to do.

Prepare the cut end of upper portion with indiarubber ring as before. Now turn in the cut end of the lower portion for about an inch and sew it up by a continuous suture which completely closes the lower bowel.

Pass the four needles through the ring as before, then incise the colon for an inch and pass the needles by Lambert suture half-an-inch from the edges of the wound. By drawing on the threads with a little assistance the edges of the colon wound turn in, and tie the ends of the same threads together; this does not cause the same puckering. Put in lateral sutures between those already placed, and here I would say, use Mr. Haswell's buried quilt suture, it answers splendidly with one quite at the mesenteric attachment. A flap can be applied if desirable.

ON SOME POINTS CONNECTED WITH THE ACCIDENTS OF ANÆSTHESIA AND THEIR TREATMENT.

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IN view of certain advances which have recently been made in the treatment of the serious accidents which are liable to happen in administering anæsthetics (I refer to Dr. B. Howard's method of raising the epiglottis*, and to Prof. McWilliam's experiments to determine the value of electricity as a direct stimulant in cardiac failure†), it may be in place to review our knowledge of the accidents of anæsthesia and their treatment.

* A new and the only way of raising the epiglottis, Dr. B. Howard. —*B. M. Journal*, Nov. 17, 1888.

† Electrical stimulation of the heart in man.—*B. M. Journal*, Feb. 16, 1889.

An accident may be defined as any event in the course of the administration which interferes with the simple process of inducing and maintaining a state of surgical anaesthesia.

Some of these accidents are of slight importance in themselves, but inasmuch as small accidents are often the forerunners of greater ones, successful results may depend upon a readiness in anticipating, and failing this, a promptitude in remedying, small accidents. I will classify the accidents as follows :—

Class I.—Those producing an impediment to free respiration.

(a) Before anaesthesia is complete.

(b) During surgical anaesthesia.

Class II.—Those in which cardiac failure threatens or occurs.

(a) Before the operation.

(b) During the operation.

(c) After the operation.

Class I. (a) Impediment to free respiration, before anaesthesia is complete, includes the following conditions :—

1. Spasm of the laryngeal muscles.

2. Delirious excitement.

3. Apnoea, *i.e.*, cessation of respiratory movements, occurring especially in children, not accompanied by cyanosis or spasms.

4. Foreign body in the air-way.

5. Pressure on the nostrils by apparatus.

It would take us beyond the limits of the present paper to discuss the causation and treatment of these conditions.

Class I. (b) Impediment to respiration during surgical anaesthesia may occur under the following conditions :—

1. Of excessive secretion in the mouth and air passages.

2. Of blocking of the air way by the falling back of the tongue, and with it the epiglottis.

1. The excessive secretion of the mucous and salivary glands, which occurs occasionally with chloroform and frequently with ether, always implies some degree of obstruction to the sufficient oxidation of the blood. The secretion occurs during the early stages, and if it can be removed it will not re-occur to any extent. It can be limited by allowing the patient to inhale only through the nostrils; this, however, is impossible where there is nasal stenosis, and also where the teeth are long and the lips short, so that in repose the lips do not close. The effects of the over-secretion can be largely prevented by placing the head on one side, with the cheek resting upon the pillow; then the secretion will collect outside the teeth, and also if the lips are closed the expiratory efforts will expel the secretion through the lips. If necessary a mouth-gag may be introduced, and the secretion

mopped out. It is wise, in every case, to remove all the secretion from the mouth and pharynx at the end of the operation, as the swallowing of this is one of the factors that produce vomiting.

2. The falling back of the tongue, the epiglottis, the aryteno-epiglottidean folds, and the velum palati have hitherto been a great source of trouble to anaesthetists. This condition commonly happens unless precautions be taken during the process of anaesthetising, and it always happens in the complete relaxation of impending death.

It is one of the ordinary sights of an operation table to see the mouth-gag introduced and the tongue seized with a pair of forceps, or even pierced and held forward with a loop of silk.

Under the present conditions of our knowledge, which we have gained by the recent teaching of Dr. B. Howard, this accident ought not to occur except in cases where, during the operation, or by previous operation, or by disease, a part of the lower jaw has been removed, or in some way the ligaments and muscles, connecting the lower jaw with the hyoid bone, have lost their normal attachments. In these cases traction on the tongue is generally a successful way of removing the obstruction, unless some appliance be introduced to raise the epiglottis directly, or unless tracheotomy be performed.

Except under the conditions enumerated, the practice of drawing forward the tongue is unnecessary, and in most cases useless. Stimulation of the tongue either by pinching it with the forceps or by traction may excite reflex contraction, which will temporarily remove the obstruction. If the stimulation does not excite contraction it is useless, and in cases where a remedy is most needed, that is, where respiration has stopped and muscular relaxation is complete, and all reflex action is lost and death is impending, it is absolutely useless. In such a condition no amount of traction upon the tongue will have the remotest effect in moving the epiglottis, and only a very slight effect in advancing the back part of the tongue from the posterior pharyngeal wall.

The anatomical relations of the parts concerned are fully discussed in Dr. Howard's paper. Suffice it to say here that the reasons why traction upon the tongue will not produce a similar traction upon the epiglottis are :—

1. The obstruction produced by the lower incisor teeth.

2. The tension of the anterior pillars of the fauces.

3. The shortness of the fraenum of the tongue.

Dr. Howard's method of raising the epiglottis, under the condition of complete muscular relaxation and absence of reflex action, consists in completely extending the head and neck, while the

mouth is kept closed; whereby a post-oral air-way is established, and respiration can take place through the nostrils. The anatomical facts upon which this practice is based are the connections of the epiglottis with the hyoid bone, and of the hyoid bone with the lower jaw. A chain of three links exists, viz.:—The muscles connecting the lower jaw with the body of the hyoid bone; the body of the hyoid bone itself; and the hyo-epiglottic ligament. Extension of the head and neck tends to put a strain upon the three-linked chain, and in the extended position of the head the hard palate becomes horizontal, and the dorsum of the tongue will rest upon it as a floor. Further anatomical considerations supporting this practice will be found in Dr. Howard's paper. In complete relaxation of the muscles it requires complete extension of the head and neck, with the jaws closed, to produce erection of the epiglottis; but in ordinary anaesthesia, when the muscles still retain their tone, the three-linked chain is shorter in proportion to the degree of tonicity which is retained, and consequently partial extension with elevation of the chin, especially if the inferior maxilla be advanced by the hand placed behind the angles of the jaw, will suffice to keep the epiglottis erect and the post-oral air-way clear. Therefore, when this physiologico-mechanical obstruction occurs, or a tendency to it as shewn by laryngeal stertor, if the anaesthetist will partially extend the head and neck, and by placing the hand behind the angles of the jaw unlock the teeth and advance the jaw, so that it becomes under-shot, the post-oral air-way will be maintained, and all stertor, except that from vibration of the soft palate in expiration, will disappear.

Consequently, except under the circumstances enumerated above, when the anatomical connexions of the parts have been disturbed, and except when the exigencies of the operation demand that the mouth be kept open, the accident of the tongue and the epiglottis falling back to obstruct the air-way need never occur. This practice of partial extension with closure of the jaw will obviate the necessity of resorting to the imperfect methods of stimulating or drawing forward the tongue.

Class II. Those accidents in which cardiac failure threatens or occurs—

(a) Before the operation.

In examining a record of deaths under chloroform, it will be found that in more than one-quarter of the cases death took place before the operation began. Death seems to be in some cases due to syncope from fear or other causes; in some, to a rapid inhalation of excessive concentrated vapour; in some, to asphyxia from obstruction of the air passages. Among the few deaths which have

occurred before the operation during the inhalation of ether, some seem to have been due to asphyxia from accumulation of secretion; some to obstruction by the tongue and epiglottis; and some have occurred in cases of strangulated hernia.

(b) During the operation.

The accidents of this class may happen at any period of the operation, but it is a remarkable fact that a large majority of the fatalities during an operation under chloroform occur in the early stages of the operation.

In about 14 per cent. of the fatalities under chloroform, the first shock of the operation determined the fatal issue.

In all these the pain of the procedure roused the patient, and then cardiac and respiratory failure ensued.

It is another remarkable fact that a very large number of accidents of this class and a large number of fatalities occur in cases of brief and trifling, but painful, operations, such as the extraction of teeth, the avulsion of toe nails, the amputation of digits, the opening of abscesses, the removal of hæmorrhoids, and the slitting up of fistulæ in ano.

An examination of these records will shew that there is one condition present which is common to them all, and that is the condition of incomplete anaesthesia under chloroform.

Chloroform depresses the action of the heart and reduces the rapidity of the blood current. If enough chloroform has been given to depress the heart, but not enough to abolish the reflex inhibition of a painful stimulus, the shock will occur which may kill. As sure as the patient responds to the first stroke of the knife, so surely may a tendency to cardiac failure be anticipated, either quickly or later on.

It is well to recognise that shock, plus chloroform, is more dangerous than shock without chloroform. It is a common phrase to hear uttered: "He will only require a whiff of chloroform, just enough to deaden the pain." It is this fallacy which is responsible for a large number of these deaths.

In the later stages of the operation under chloroform the causes of the accidents of cardiac failure seem to be:—

1. Incomplete anaesthesia at the beginning of the operation, whereby the vitality is lowered.
2. An excessive amount of chloroform vapour inhaled.
3. Insufficient vitality to bear the smallest amount of chloroform necessary to maintain surgical anaesthesia.

(c) After the operation.

During the recovery of consciousness a fatal syncope occasionally has occurred after an operation under chloroform. The causes of these are far to

seek ; it is probable that the exhaustion due to the efforts of vomiting has in some cases produced the fatal syncope.

Of all the variety of methods that have been devised for the resuscitation of patients about to succumb to the effects of anæsthetic intoxication, the few that have stood the test of experience have been somewhat modified since Dr. Howard has given his latest contribution to the knowledge of anæsthetics. Except in the case of mechanical obstruction to the larynx by the presence of a foreign body, Howard's method of raising the epiglottis stands as an essential element in every case of artificial respiration, and has superseded the use of tongue forceps. Artificial respiration is the one staff that will give support in these grave circumstances.

How, then, ought it to be carried out? If a man administers an anæsthetic single-handed, and it becomes necessary to resort to artificial respiration in the case of an adult, his efforts will in all probability be futile, for there is no means of performing artificial respiration single-handed. For young children, as opposed to adults, where the thorax is flexible and elastic, there is one satisfactory method of artificial respiration, which is as follows :—With one hand under the lower jaw and the other spread on the front of the chest, alternate compression of the chest and extension of the head and neck will produce an alternating current of air out of and into the lungs very effectually. This can be done without interrupting the operation. If two skilled hands—A and B—are present, the patient should be drawn to the end of the table or bed, and the head allowed to hang freely. A will then apply Dr. B. Howard's method of raising the epiglottis, while B will apply Dr. B. Howard's method of artificial respiration, kneeling astride the patient, compressing the chest with his hands, and with his elbows against his hip bones, bearing forwards, and then suddenly throwing himself up from his hands. He will repeat this alternate compression and relaxation of the chest about 14 times a minute. If a third person (C) is present, partial inversion may be added to artificial respiration. The patient in this case, if the operation is performed on a table, may be drawn down so that his legs hang free. This end of the table may be raised, and pillows, or the end of the mattress rolled up, should be arranged to support the shoulders, so that the head and neck are free to be fully extended. Thus A will apply Howard's method of raising the epiglottis ; B and C, after raising one end of the table, and, if necessary, tying the patient's leg to the leg of the table, will perform Silvester's method of artificial respiration. If a fourth person (D) is present, he may, after assisting the preliminaries

and injecting stimulants, Faradise the phrenic nerve. He should place one pole well behind the middle of the right sterno-mastoid muscle, and the other in the right axillary line at the sixth interspace. He must remove the lower pole each time the arms are lowered. If the heart has stopped beating, no method hitherto practised will ever be likely to restore it.

As regards the action of electricity upon the heart, although in the normal heart not influenced by chloroform direct stimulation by the Faradaic current may increase the force of the beat and raise the blood-pressure, yet this is not the case in chloroform narcosis, nor in other conditions of cardiac syncope.

Experimental and clinical experience in cases of sudden cardiac failure induced by reflex inhibition from blows upon the epigastrium, and from the shock of pain under the depressing influence of incomplete anæsthesia, have shewn that direct stimulation of the heart, by rapidly repeated induction shocks, is almost certain death. Dr. John McWilliam has lately published the result of a number of experiments upon mammals bearing upon this subject, which gives some ray of hope that in electricity we may have a further means of saving life in impending death from cardiac failure, when the shock of pain in incomplete anæsthesia has produced immediate syncope. There is no reason to believe, however, that his suggestion will be of any avail where the heart has failed from the purely toxic effects of chloroform upon the medullary cardiac centre, or the ganglia of the heart, or the cardiac muscle, whichever it may be, that is the part chiefly affected in chloroform intoxication. When the heart is directly stimulated by the ordinary interrupted current, the cardiac muscles, or rather groups of fibres, are thrown into a state of fibrillar contraction ; the muscles do not act together so as to produce an obliteration of the cavity of the ventricle or auricle. There is no artificial systole, but merely an aimless twitching of a number of fibres, serving no purpose but to exhaust their contractility. On the other hand, Dr. McWilliam has shewn that if a periodic series of single induction shocks are thrown into the heart muscle by large electrodes, a rhythmic contraction of the heart, as a whole, results, producing a real artificial systole. He finds that a single induction shock produces a systolic contraction, and a regular series of single induction shocks at the rate of 60 or 70 a minute produces a corresponding series of contractions, which actually pump blood from the cavities of the ventricles into the pulmonary artery and the aorta. He regulated the periodic shocks by a metronom. He states that to produce the best results in man the electrodes should be large,

and one applied over the area for cardiac impulse, and the other over the fourth dorsal vertebra behind, and that the shocks should be strong enough to excite a powerful contraction in a voluntary muscle. This is the only form in which electricity applied to the heart is likely to be of any service in efforts at resuscitation, and it is only likely to be of service in cases where the syncope is due to the effects of shock in incomplete anæsthesia.

COMPLETE RUPTURE OF PERINÆUM, INVOLVING THE RECTUM FOR AN INCH-AND-A-HALF, WITH LOSS OF CONTROL OVER SPHINCTER ANI.

By J. CARNEGIE McMULLEN, L.R.C.S.I.,
L.K.Q.C.P. IREL., LATE HONORARY
SURGEON, AUCKLAND HOSPITAL, N.Z.

M. D., aged 34 years, was delivered of her first child, a male, on 13th July, 1885. The labour was tedious, child large and maternal parts rigid. Forceps were used and the child born with great difficulty, the perinæum was ruptured and the rectum torn for an inch-and-a-half. The wound was brought together with deep sutures and quills at the time, but gave way with the exception of a small bridge of skin, at first evacuation of the bowels.

Since that time there has been no control over the sphincter ani, causing great misery when the motions were at all soft, and at all times a sense of weight, fatigue, and bearing down, the uterus was somewhat low in the pelvis, but no actual prolapse.

She was again delivered on 3rd July, 1887, of a female child, also by instruments, though the labour was less difficult than the first. The small bridge of tissue remaining from previous operation now gave way. No control over bowel since, and the distressing symptoms due to want of support increasing.

The patient was prepared for operation by rest in bed for two days, the bowels being well cleansed twice by Hunyadi water and the vagina washed out night and morning with hot water and Condy's fluid.

Operation.—May 29th, four days after cessation of menstrual flow.

The anæsthetic chosen was chloramyl (amyl nit. m vii ss, chloroform ʒi). The patient was placed in the lithotomy position with Clover's crutch. The surfaces were freshened from below upwards

with scissors in a butterfly shape, with wide wings, the narrowest part between the wings extending on the posterior vaginal wall, fully half-an-inch above the apex of the rectal tear. Still with scissors, snipped nearly half-way round the anus on either side, to fully expose the torn sphincter, removing at same time two small external piles.

The edges of the rectal tear were now pared with a knife (to avoid bruising) and the parts were ready for the sutures.

Commencing at the apex of rectal tear, three fine silver wire sutures were placed, twisted in the rectum and left protruding from the anus, guarded by a piece of fine indiarubber tubing. Then commencing from below, four stout wire sutures traversed the freshened surface, buried in the recto-vaginal septum, entering and making exit about a quarter-of-an-inch from the margins of the freshened surfaces; the superior suture appeared on the posterior vaginal wall above the narrowest part of the denuded surface.

These were brought firmly together and twisted, each pair being left long and guarded by indiarubber tubing. A strong carbolized gut suture was now placed through the anterior margin of the anus to strengthen the parts just brought together, and to support the sphincter during union; a like suture was placed at the posterior vaginal commissure, with the object of preventing dragging on the wire sutures during irrigation &c., thus promoting union during the first forty-eight hours, a most important period, before the end of which the bowels should be cleared.

The diet during preparation for and after operation consisted of beef tea, chicken broth, milk and soda-water, tea, coffee, and a little wine.

The patient had a severe attack of retching while under the anæsthetic, and before the sutures were completed, but no harm resulted.

May 30.—*Second Day.* Vomiting troublesome; ice, champagne, hypodermic of morphia, gr. $\frac{1}{6}$ and atropia $\frac{1}{120}$; vagina and rectum washed out.

May 31.—*Third Day.* Vomiting ceased; injected olive oil ʒvi.

June 1.—*Fourth Day.* Hunyadi water at 8 a.m.; injected olive oil ʒiv at 9.30; large soft motion at 1.15 p.m.; no injury.

June 2.—*Fifth Day.* Hunyadi water at 8 a.m.; motion as before at 9.15.

June 3.—*Sixth Day.* Restless, some pain, no motion; vagina and rectum washed out.

June 4.—*Seventh Day.* Slight motion; wound looks well; feels weak.

June 5.—*Eighth Day.* Hunyadi water; oil injected; full soft motion; no pain; feels well.

June 6.—*Ninth Day.* Washed out vagina and rectum; gave chloramyl, and removed all the perineal sutures and one rectal, which came away easily; placed a silver suture in anterior margin of anus for support; vomited freely, but no injury to parts. 4 p.m.—No further vomiting; took beef tea and a little wine; vomiting again at 7 p.m.; gave dilute hydrocyanic acid. 9 p.m.—No vomiting.

June 7.—*Tenth Day.* No vomiting or pain; quiet, bowels unmoved.

June 8.—*Eleventh Day.* No pain; remaining two rectal sutures came away; feels comfortable; wound clean and sound.

June 9.—*Twelfth Day.* Hunyadi water at 8 a.m.; bowels moved easily.

On the next day I found that a small piece of hardened faeces the size of half a split pea had forced its way through at the situation of the lowest wire suture, making a small recto-vaginal fistula through which a probe could be passed; four days later this had completely healed. The perineal body is now normal in size and shape, strong and sound. Complete power over the sphincter ani was regained by the fourteenth day after operation. The patient was last seen on 9th July, when she was perfectly well and said she felt ten years younger.

The points to which I would specially draw attention are:—

1st.—Preparation of the patient. A time should be selected when she will be free from domestic or other worries, thus conducing to the best physical and mental condition. She should be resting in bed for fully one day before operation, and for three or four days previously the vagina should be frequently irrigated. The bowels should be thoroughly cleared some hours before operation, the purgative I prefer being Hunyadi water. It is prompt and full in action, causing no griping or after disturbance.

2nd.—The size of the surface denuded. This should be as large as possible, being both high and wide for what appears to be a very large surface will contract into a very small perineum.

3rd.—The importance of giving only fluid nourishment and as little of it as will adequately support the patient's strength, so that no lumpy motions may be formed. From 24 to 36 hours after operation a large dose of Hunyadi water should be given, 3vi of olive oil having previously been injected, and if that does not produce a full soft motion within a few hours five or six ounces of warm olive oil should be injected through a long thick gum elastic catheter passed in about eight or ten inches.

4th.—The necessity for frequent bathing, &c. During convalescence I direct the nurse to bathe

the vulva and anus with warm antiseptic solution every three or four hours; and twice daily for some days I wash out the vagina and rectum myself, never leaving this to be done by the nurse.

5th.—The rectal sutures. Most authorities advise that gut sutures be used for the rectal tear as they become absorbed and do not require removal; but they also sometimes loosen or become untied before their work is done, and for this reason I prefer fine wire. It causes no discomfort if the sutures are guarded where they pass through the anus, will keep the parts in firm apposition, and come away with the gentlest traction after six or seven days. If not they can easily be removed by passing a small cylindrical vulcanite speculum, and snipping the wire where exposed in the opening.

6th.—In passing the perineal sutures it is best to bring the needle out in the middle line and re-enter it, as there is great difficulty and no advantage in passing the sutures from side to side in one sweep.

I believe that in the majority of cases, if all these precautions are carefully observed, that the operation will give a satisfactory result, obviating the necessity for secondary operations and restoring the power over the sphincter without delay.

I have only now to apologize for the length of this paper, and must plead in excuse the interest and great importance of the subject.

P.S.—Extract from letter from the patient written on 15th July, 1889, nearly fourteen months after operation, which was performed on 29th May, 1888.

"The operation has been in every way most satisfactory. I have complete control over the bowel; never suffer from constipation, in fact am particularly regular in that way, and except that occasionally when having walked too far I have slight pain, I am as well as I ever was. There still remains the small place I told you of which did not join up, but I do not suffer any inconvenience from it."

"I meant to say somewhere above, many thanks for all you have done for me; you can point to me and say, 'behold the woman who was made whole.'"

The small place alluded to is where the little piece of hardened faeces became impacted in the wound, and was not noticed by me for two or three days when I removed it; but for this accident the operation would have been perfect. The tiny track left is so low down that as the patient says herself, she suffers no inconvenience whatever from it.

58 Collins-street East, Melbourne,
October 1, 1889.

A CASE OF CLOSURE OF THE JAWS FROM SPASTIC IRRITATION OF THE MASSETER DUE TO IRRITATION OF AN UNCUT WISDOM TOOTH.

By ROBT. DENHAM PINNOCK, M.D., Ch.M.,
HON. SURGEON TO THE BALLARAT HOSPITAL,
VICTORIA.

THE rarity of cases of this kind induces me to publish the following notes :—

John McL., *æt.* 27, married, sawmiller, residing 30 miles from Ballarat, consulted me on the 19th August with this history :—

Relatives all healthy ; never suffered from any disease himself, except a mild attack of jaundice four years ago. Was in good general health until five weeks ago, when he began to suffer from intermittent pain in the region of the left masseter muscle. For this he tried various external remedies, without avail, and continued to do so for four weeks, when he noticed that the gum was swelling behind the last tooth of the lower jaw on the left side. This swelling became exceedingly painful, and on the following day he found that he could not separate the jaws more than a quarter-of-an-inch. He continued rubbing pain-killer on the cheek, and applying hop poultices without effect for four days, during which period he lived on liquids administered in a spoon. On the fifth day of the closure he came in for advice.

I found it impossible to separate the jaws more than a quarter-of-an-inch, and the attempt to do so gave him great pain. By means of a reflected light from the frontal mirror, and keeping the tongue out of the way with a catch forceps, I was able to examine the cavity of the mouth, and saw a minute portion of the outer edge of the crown of the wisdom tooth projecting from the gum at the left side of the lower jaw. The wisdom tooth on the opposite side was fully erupted. As there appeared to be insufficient space between the second molar and the ramus of the jaw for the eruption of a tooth of corresponding dimensions to the opposite molar, and having in view the history given above, and the absence of any other discoverable cause for the closure, I took him on the following morning to Mr. McBurney, a dentist of high repute in this city, and requested him to try and remove the wisdom tooth, and if he found that impossible, to take out the adjoining molar. Chloroform was given, and even when thoroughly anæsthetized we could not separate the teeth more than three-fifths of an inch. Finding it impossible to remove the wisdom tooth even after freely dividing the gum over it, Mr.

McBurney with great difficulty succeeded in removing the adjoining molar. The patient had to be kept fully under the chloroform, as the jaw began to close directly its administration was interrupted. The effect of the removal of this tooth was very marked, the patient on coming to his senses being able to separate the teeth to the extent of an inch without assistance and without pain. On the following day he was able to open his mouth to its fullest extent, and all the pain which he had been suffering for so many weeks had gone. He returned to his home a few days afterwards, and has had no relapse.

Mr. McBurney has kindly furnished me with the following particulars about the tooth extracted :—

From the crown to the apex of the fangs it measured $1\frac{1}{8}$ in.

The expansion of the fangs in the line of the jaw (from before backwards) was three-fifths of an inch.

The angle of the distal fang was 30 degrees.

The mesial fang was bifurcated

Mr. McBurney tells me that he has never met with such a degree of expansion in the fangs of a tooth as the above, and that the irritation of an uncut wisdom tooth in the presence of such crowding must have been very great.

CASE OF LONG-STANDING EMPYEMA IN ADULT, RESECTION OF RIB AND EVACUATION OF PUS.—CURE.

By T. J. HENRY, L.R.C.P.E., &c., MEDICAL
OFFICER WARRIALDA DISTRICT HOSPITAL,
NEW SOUTH WALES.

W. K., *æt.* 25, shearer and general bush worker, was admitted into the Warialda Hospital on April 2nd last. On admission he was so weak as to be unable to stand. His limbs were wasted to size of broomsticks. He weighed about seven stone. His lips were markedly cyanosed. He had great dyspnoea. He was unable to assume any decubitus other than on the left side. Thoracic examination revealed in brief : Left side much distended and subcutaneous oedema marked ; marked dilatation cutaneous over right side of the respiratory movements almost totally absent on left and markedly diminished on right side ; vocal fremitus absent on left, diminished on right side. Percussion showed absolute dullness all over left lung. On anterior aspect of right lung note impaired above third rib ; and below third rib marked dullness, merging into hepatic dullness. Externally,

on right side note becomes fairly resonant at anterior axillary line and perfectly so in mid-axillary line, normal posteriorly.

Auscultation showed breath sounds absent over whole of left chest; almost absent over lower portion of right and impaired over upper portion. Normal externally and posteriorly.

Cardiac impulse feeble and felt in fifth right interspace, one with *external* to right nipple.

Patient stated that three and a half years previously he had had pleurisy on left side, but whether with effusion he was not aware; at any rate he was not aspirated. He was "delicate" thereafter and often had pains in left chest. His present illness he dated from two years prior to admission, when he had to seek medical assistance and was aspirated, a quantity of pus being drawn off. He was then better for a time, but after some months the symptoms returned, and he was again laid up. He then began to expectorate large quantities of pus (undoubtedly spontaneous trans-pulmonary evacuation of Empyema) and continued so doing from April till October, 1888. After each expectoration he felt much relieved in breathing. He then felt moderately well and the expectoration of pus ceased. During this period he believed himself to be hopelessly ill with Phthisis, but towards the latter part of last summer he became very weak and applied for admission, as reported, on April 2nd. From his admission he was under the care of Dr. P. J. Kelly (who was acting as *locum tenens* during my absence in Sydney, and to whose courtesy I am indebted for the notes of patient's history and condition on admission) who suggested operation to the patient. On April 17th I resumed my duties, and after consultation with Dr. Kelly I decided to remove a portion of rib and drain the affected pleural cavity. On April 18th I did so; Dr. Kelly administered the anæsthetic, and I, after scraping off and preserving the periosteum, cut down over the seventh left rib and removed three and a half inches in the axillary line. The pleura I found greatly thickened. On opening through into the cavity 200 ounces of pus welled forth. The cavity was then carefully washed with 1 in 40 carbolic, a shoulder tube inserted, the soft tissue sutured, and a dressing of tenax applied.

For a few days after operation patient was very weak and had frequent vomiting and retention of urine. The wound required to be dressed twice daily—each time the cavity being well washed with antiseptic lotion—on account of the great exudation of pus.

The temperature, however, never went over 99° (excepting once, after catheterism, when it reached 100.5°), and the pus was maintained in an aseptic condition. After five days the patient began to

grow stronger and to increase in appetite. For some time he put on flesh, at the rate of over a pound a day. The discharge gradually ceased, and at length disappeared. On July 16th I finally withdrew the tube and allowed the opening to close. Since then the patient has been doing general bush work, and sometimes camping out, and he is now engaged in shearing. He is stout and well. He has no cough, weighs almost ten stone, and the wound has healed perfectly. Breath-sounds are deficient, and dulness fairly marked over left side of thorax, as would be expected after such prolonged compression of the left lung—indeed, of both lungs—with thickening and subsequent granulation of the pleura. There is noticeable retraction of left chest wall, antero-laterally. The apex beat of the heart is slowly creeping leftward, and is now slightly to left of mesial line of sternum.

The points I think chiefly worthy of notice in the above case are:

- (1). The prolonged history of the disease.
- (2). The enormous amount of pus evacuated.
- (3). The *complete* and fairly rapid cure effected in an *adult* of a disease notoriously liable to persist, despite treatment in patients whose periods of childhood and adolescence have passed.

Addendum.—On October 14th I had another opportunity of examining the above patient. There was less dulness over left chest, and the apex beat is now two inches to left of sternum—i.e., almost in normal position.

A CASE OF HYDRAMNIOS.

By LL. DAVENPORT PARRY, L.R.C.S. ED.,
MEDICAL OFFICER VEGETABLE CREEK
HOSPITAL, EMMAVILLE, N.S.W.

On the 21st September I received an urgent summons to attend Mrs. S. at a place 20 miles distant from my residence, the messenger being able to give me little or no information as to what was the matter, except that the woman had great difficulty of breathing and seemed "puffed up" (*sic*). Revolving various possibilities in my mind from ascites to asthma, I started on my journey, and on arriving at my destination found the state of affairs as follows. Mrs. S., *ætat* 25, was sitting propped up in bed, respiration shallow and extremely embarrassed, the abdomen enormously distended. She stated that she was in the fifth month of pregnancy, that she had "quickenened" a fortnight previously, at about which time she thought she had caught cold through getting her feet and lower part of body wet while washing; this was her fourth pregnancy,

the former ones having been normal; that she had commenced to swell about ten or twelve days previously, and had rapidly arrived at her present state. Upon examination the contour of the uterus could be distinctly made out, unobscured by any surrounding fluid; the foetal limbs could not be made out on palpation, nor did the stethoscope reveal the usual foetal or placental signs of pregnancy; the vagina and vulva were of deep violet hue, and examination per vaginam showed the lower segment of the uterus unusually distended and the presenting part not appreciable. The bowels had not been moved for four days, and while feeling a great desire to micturate, she had been unable to do so for nearly 24 hours. I at once relieved the bladder with the catheter, and dispatched a messenger for my gynaecological bag, having determined to puncture the membranes as the only way to relieve the extremely urgent symptoms. In the meantime I administered a brisk cathartic and gave stimulants by the mouth.

In three hours time the bowels were moved, and while the patient was sitting on the commode the membranes ruptured spontaneously, and a discharge of fluid occurred which completely filled the vessel she was sitting on and overflowed it; the patient fainted, but on being got back to bed and the usual restoratives applied, she soon rallied, labour pains came on, and in five hours she was delivered of a foetus of apparently the fifth month of pregnancy, and which had apparently been dead for some time. Finding the abdomen still distended, I made a further examination and found a second amniotic sac presenting; this I ruptured and the patient was shortly afterwards delivered of a second foetus similar to the former. The case thereafter proceeded favourably, and the patient made a rapid recovery.

Remarks.—I have ventured to report this case for the following reasons:—

1. Its comparative rarity.
2. The great rapidity of its course, the pregnancy having proceeded normally up to the period of "quickening" at the end of the fourth month, and the effusion of fluid having occurred during the ensuing 12 or 14 days.
3. In twin pregnancy, when this disease occurs, generally one ovum alone is affected. In this case both sacs appeared equally distended, and each foetus presented similar appearances.
4. I should be glad to obtain the opinion of some more experienced obstetrician whether I was right in resolving to puncture the membranes in order to relieve the symptoms at so early a period of pregnancy; and also whether the "getting cold" as described by the patient could have had any influence as "cause and effect" on the excessive and rapid secretion of liquor amnii.

PROCEEDINGS OF SOCIETIES.

NEW SOUTH WALES BRANCH OF THE BRITISH MEDICAL ASSOCIATION.

THE 85th general meeting of the Branch was held in the Royal Society's Room, Sydney, on Friday, 4th October, at 8.15 o'clock. Present: Dr. Fiaschi (President) in the chair; Drs. Twynam, Crago, Sydney Jones, Newmarch, Hankins, Wm. Chisholm, Clubbe, Jarvie Hood, Beith, Wilkinson, G. A. Marshall, Brady, Quaife, McDonagh, Rennie, Worrall, Martin, Hodgson. Visitor: Dr. McSwinney.

The minutes of the previous meeting were read and confirmed.

The PRESIDENT read a letter from the Hon. Dr. MacKellar, M.L.C., calling attention to an urgent case of distress in a medical gentleman. A subscription list was opened.

A letter from the Hon. Dr. MacLaurin, M.L.C., stating that he had attended the meeting of the British Medical Association at Leeds, was read.

DR. ROBERT BEITH, of Summer-hill, was elected a member of the Branch.

DR. GEO. TWYNAM read a paper on some recent cases of "Intestinal Surgery," and exhibited some specimens of enterorrhaphy and ileo-colostomy.

DR. SYDNEY JONES said the members of the Branch should be thankful to Dr. Twynam for his exhaustive paper, and also the elaborate specimens prepared to illustrate the operation. He (Dr. Sydney Jones) did not intend to discuss the paper, but there was one point in which he could fully bear out Dr. Twynam's recommendation, and that was to carefully look for second bands of obstruction. There are, no doubt, many cases of perforation of the appendix which should be relieved by operation.

DR. FIASCHI said he did not quite agree with Dr. Twynam as to waiting until the vomiting became offensive before deciding upon operation, but would rather judge by general symptoms; and as regard the specimens exhibited he (Dr. Fiaschi) thought it would be well to try the effects of the operation before deciding finally in its favour.

DR. TWYNAM in reply thanked the members for their very close attention, but would have liked more discussion upon the subject as there were many points left untouched. With regard to the length of time up to which it is possible to get relief from the ordinary methods such as inflation, distension with water, &c., about 40 hours is the time, but one case has been recorded where a patient was relieved after seven days, and in another after 37 days.

DR. CLUBBE proposed "That in the opinion of this Branch of the B.M.A., when dealing with Friendly Societies, its members should use the agreement that was drawn up by a sub-committee appointed by the Branch some time ago."

A discussion took place in which Drs. Hodgson, Twynam, Crago, Newmarch and Worrall joined.

A letter from Dr. Machattie of Bathurst bearing upon the subject of the agreement was read by the President.

The motion of Dr. Clubbe was carried unanimously.

MR. BRUCK has received a new supply of *Beck's Microscopic Staining Solutions and Mounting Fluids*, particulars of which will be found at end of book-list in this issue.

**SOUTH AUSTRALIAN BRANCH OF THE BRITISH
MEDICAL ASSOCIATION.**

MONTHLY MEETING held at the Adelaide Hospital on Oct. 31. Present: Drs. Cleland (President), Cawley, Thomas, Gardner, Marten, Todd, Jay, Giles, T. K. Hamilton, Stewart, A. A. Hamilton, and Lendon.

An apology was received from the Hon. Sec. (Dr. Poulton), who was unable to attend.

Exhibits were shown by Drs. Hayward, Gardner, Thomas, Evans, and Todd.

DR. GARDNER made a Report from the Medical Committee, with reference to the proposed Medical Act.

DR. GARDNER read the following paper on

**TWO CASES OF LORETA'S OPERATION
FOR PYLORIC STENOSIS.**

By WM. GARDNER, SEN. SURGEON ADELAIDE HOSPITAL, AND LECTURER ON SURGERY, ADELAIDE UNIVERSITY.

THE first patient upon whom I operated was sent to me by my friend, Dr. Baly, of Yorketown, with a note stating that she had long suffered from pyloric obstruction, and that he considered the case a suitable one for trying Loreta's operation. Every form of treatment had been tried by him for months, and after consultation with my colleagues, I determined to make the attempt, and as the evident thickening of the pylorus might turn out to be malignant, I made every preparation for performing pylorotomy should it be deemed necessary. For the same reason I made use of a transverse incision, such as Billroth recommends for pylorotomy, and I found this quite convenient for the other operation. The following is the case:—

J. H., aged 43, admitted to Adelaide Hospital 15th July, 1888. History.—Patient complains of sickness and pains in the region of her stomach. When she takes anything it usually lies on her stomach and makes her feel very sick. She has been troubled with indigestion off and on for several years, but during the last three months it has got very much worse, and patient finds her strength failing. As a rule she vomits every other day, and generally in the evening. Sometimes, however, she goes for four or five days without being sick, and then vomits up over a chamberful. The pains across the upper part of her abdomen are of a shooting character, and made their appearance about three months ago. They are very much worse just before vomiting on account of the distension of the stomach with gas which has then occurred. The pains increase in proportion to the amount of flatulence present. Previous health has been good, as is also the family history. Has been married twenty-four years and has had nine children, the youngest being five years old. Climacteric three years ago.

Present Condition.—The stomach is of variable size, but distinctly enlarged, and on some days its outline can be traced on the abdominal walls. To the right of the median line and just above the umbilicus may be felt a lump about the size of a walnut, which moves up and down with the movements of respiration. The vomited matter is of a yeasty character, very acid, and contains sarcinæ in abundance. Urine is acid, and contains neither sugar or albumen.

Professor Rennie kindly examined the vomited matters and reports just a trace of free hydrochloric acid.

July 19.—Complains of a boring pain in her stomach.

July 26.—Patient anaesthetised and stomach washed out with two pints of weak boracic lotion.

July 30.—Patient anaesthetised and stomach washed out with five pints of the lotion. The tumour could be felt readily on each of these occasions.

August 4.—Patient has been on milk diet and has not been sick since first washed out. To have milk, baked apples, &c.

August 6.—Patient sick this evening and last night.

August 7.—Patient vomited again this evening.

August 11.—Patient partially anaesthetised and stomach washed out.

The Operation.—On the 12th August, 1888, the patient having been placed under the influence of ether, Dr. Gardner performed the following operation:—(The stomach was thoroughly washed out with a boric acid solution.) A transverse incision about four inches long was made in the epigastric region and the skin, muscles and fascia down to the peritoneum were rapidly divided. All bleeding points were ligatured with wallaby tendons, and the application of hot sponges for a few minutes effectually stopped the oozing before the peritoneum was opened. Although no tumour could be recognised in the neighbourhood of the pylorus, the walls of that part of the stomach were very hard and greatly thickened. A portion of the viscus was then drawn out through the opening in the abdominal parietes without difficulty, as no adhesions were present. After the extended part had been carefully surrounded with hot sponges, an opening one inch long, running in the long axis of the organ was made with scissors, through which the operator inserted the forefinger of his right hand. On examining the pyloric orifice he found it almost completely closed, and it was with some difficulty that a No. 6 gum elastic male catheter was made to pass through it. After patiently boring with the right forefinger the passage was gradually opened up, the forefinger eventually being passed with ease

from the stomach into the duodenum. The hæmorrhage was very slight indeed, and the interior of the stomach having been cleansed immediately before the operation no difficulty was experienced with the stomach contents. The wound in the gastric wall was brought together with great accuracy and in a most satisfactory manner by means of Gussenbauer's sutures, which were introduced with specially curved needles, and an interval of about two millimetres allowed between each. Fine silk was employed. All the stitches were placed in position before any were tied. The wound in abdominal wall closed in the usual manner.

August 12, Evening.—Patient complaining of pain since the operation; no vomiting; enemata of milk $\text{z}\text{i}\text{j}\text{s}$, and brandy zs , every eight hours. Enemata of port wine every eight hours $\text{z}\text{i}\text{i}\text{j}$; R . strychninæ, gr. $\frac{4}{5}$; glycerine, zij ; aquam ad zij . fifteen drops ($\frac{1}{10}$ gr.) hypodermically every four hours.

August 13.—Patient slept very little during the night; wind troublesome; passed urine at 2 a.m., 10½ozs.; temperature, 100°; pulse, 125; enema of soap and water; no vomiting.

August 14.—Patient slept well during the night; passed flatus per rectum, and found great relief; no vomiting.

August 15.—Bowels not open; has passed flatus. There is no abdominal distension, but complains still of flatulence. There is some pain in her stomach.

August 16.—Very restless during the night; still complains of flatulence; no vomiting; gruel, a teaspoonful every two hours.

August 17.—Slept very little during night; still passing flatus per rectum, causing pain; no vomiting after giving gruel; one stitch removed. 6.15. p.m. patient comfortable; Supp. morph. gr. $\frac{1}{4}$; mitte one every six hours; enemata of brandy and milk.

August 18.—Complains of very little pain; still much flatus passing per rectum; bowels moved at 3.30. p.m.; no vomiting; one teaspoonful of scraped rump steak every four hours. Give ten drops of ac. hydrochlor. dil. quarter-of-an-hour before, and then gr. iij of pepsin immediately after. A teaspoonful of milk, and two teaspoonfuls of limewater every four hours alternately with the beef; enemata of milk every four hours; injection of strychnina, twice daily, gr. $\frac{1}{10}$.

August 19.—Wound dressed; a little discharge; stitches removed.

August 20.—Wound dressed; looking well; there is a little inflammatory hardening about the wound; enema of soap and water, and bowels moved well.

August 21.—Omit raw meat; give chops and fish instead, and also bread and butter; enemata every six hours only.

August 22.—No vomiting; complains of pain in her right side.

August 24.—There is a little discharge from the centre of the wound. R . Liq. strych. $\text{m}\text{i}\text{i}\text{i}$, aq. ad. zi thrice daily before food.

August 28.—The edges of wound are uniting fairly well; the skin is a little inverted at the edges; still inflammatory hardening about the wound.

August 29.—Patient complains of pain in her stomach; no vomiting; food does not cause her trouble.

August 30.—Still has crampy pains in her stomach at night; relieved last night by some warm water and brandy; scarcely any discharge from the wounds.

September 7.—Patient says that she "feels fine;" never feels sick, but nearly every night she has pains of a burning character about her stomach; she eats bread and butter, eggs, toast, cake, mutton, beef, custard, and drinks milk and cocoa; she does not take pudding, vegetables or tea.

The temperature rose above 100° on only one occasion. For the short notes of the case I am indebted to my dresser Mr. Verco; and the account of the operation was written for me by Dr. Giles who assisted.

On December 24, 1888, Dr. Baly, at my request, kindly sent me the following note after examining the patient:—

"Patient looks and feels perfectly well, and has evidently gained flesh in a marked degree; weight 7st. 10lb. (weight before operation not known, but Mrs. Hewton thinks she must have gained a stone). Has never vomited since the operation, and has had no pain since leaving the hospital; is able to eat ordinary diet without inconvenience, but has felt somewhat uneasy after eating beef, cabbage, or rich cake; can eat mutton, poultry, fish and farinaceous puddings, and drinks tea three or four times a week; no flatulence, heartburn or eructations now after food; bowels regular; ate green peas several times during the season without any bad effects. Examination:—Abdomen well covered (instead of appearing a mere envelope of skin, as it did before operation); skin over site of operation freely movable; some induration still to be felt in the region of the pylorus; gastric resonance not increased upwards, or to the left." He adds: "You will recollect of course, that before the operation even a little milk used to cause Mrs. H. great agony."

—A note from Dr. Baly, dated October 27, 1889, furnishes me with the latest information regard-

ing this patient. He says:—"She expresses herself as feeling 'better than she has done for the last six years,' and her appearance fully confirms the statement. Her face is well filled out, and has a healthy colour—a marked change from the worn, thin, sallow countenance she had 15 months ago. Her present weight is 8st. 8lb., being a gain of 12 lbs. since last report. She can now eat and enjoy ordinary food, but has to be careful; bowels act regularly without medicine. The abdominal walls are much plumper than they were. The scar is simply a thin red-dish line, and the skin is freely movable in every direction over it. There is no sign of dilatation of the stomach and no trace of enlargement or induration about the pylorus."

Mr. S. consulted me first on 17th August, 1886. He was suffering from a severe attack of gastric catarrh with very great dilatation of the stomach. A large quantity of frothy fluid had been brought up, which, on examination, was found to contain sarcinæ. He was treated with bismuth and morphia after the attack and rapidly recovered. Similar attacks occurred at about intervals of two and three months during 1887 and 1888, in nearly all of which he was seen by Dr. Stirling, who concurred in the diagnosis of gastric catarrh, pyloric stenosis and dilatation of the stomach. The attacks gradually became more prolonged and less easily recovered from. Washing out of the stomach with thymol solution (1 in 1000) was resorted to, and the patient was taught to pass the stomach tube himself, and in this way many attacks were aborted. During 1888 it was found that the hypodermic administration of morphia was the only remedy which gave any relief. Towards the latter end of 1888 the attacks became so frequent and he emaciated so rapidly that I feared some malignant change had occurred in the pylorus, and in addition to taking Dr. Stirling's opinion I called in Dr. Verco, who thought it extremely probable that some such change had occurred. We discussed the question of operation, but owing to the age of the patient (62) we did not feel that we could conscientiously recommend him to undertake the risk. After this he improved again, and with the diligent use of the stomach tube managed to get on fairly well until May, 1889, when he sent for me and said that he had determined to have an operation performed, even though the risk might be great. Under these circumstances I consented, and on May 2, 1889, Dr. Todd administered ether, and with the kind assistance of Drs. Stirling and Giles I operated by the transverse incision recommended by Billroth for pylorotomy. The stomach was easily found, drawn up to the surface, opened in a longitudinal direction for 1½

inches just behind the pylorus and midway between the curvatures. The forefinger could not be introduced, and a very small Hegar's dilator could only be passed. One size after another was then introduced until at last two fingers could be introduced at once. The wound in the stomach was closed by Gussenbauer's sutures placed $\frac{1}{2}$ inch apart, the terminal ones being inserted beyond the line of incision so as to prevent leakage. The abdominal wound was closed in the usual way. Rectal enemata were resorted to for five days, and morphia given hypodermically in the same doses as before the operation. The wound healed by first intention, and the highest temperature recorded was under 100° F. No vomiting occurred for weeks, and the patient continued to make satisfactory progress until the end of July, when violent hæmorrhage from the stomach set in. The usual remedies were employed, but the bleeding persisted and death occurred on 4th August, 1889.

A *post-mortem* kindly made for me by Professor Watson revealed an ulcer of the stomach near the pylorus, which had been the cause of the contraction and led to the fatal termination.

These cases are interesting as being the first examples of Loreta's operation in Australia.

This operation was introduced and designed by Professor Loreta, of Bologna, who performed his first operation September, 1882. A full account of this was published by Mr. Holmes in the *B.M.J.*, February 21st, 1885. On April 26th, 1884, in the same journal is given a short account of Professor Loreta's ninth operation, which was for contraction of the cardiac orifice.

The operation has been practised by a few other Italian surgeons, and in two cases by McBurney, of New York, notes of which are to be found in the *New York Medical Journal* of January 16, 1886. Two cases only have been operated upon in England, one by Mr. Frederick Treves, of the London Hospital, and the other by Mr. Haggard, of Hull.

So far as I know the remote results of these operations have not yet been published, although the immediate results of the cases have been excellent. The operation is suitable for cases of simple cicatricial or fibrous narrowing of the pylorus, or the cardia or lower end of the œsophagus. The narrowing in simple cases is due to hypertrophy of the inorganic muscular fibre, and over-distention of this is the object to be arrived at, and the result is said to be as good as in cases of over-distention for fibrous stricture of the rectum.

Reasoning from analogy every surgeon would be disposed to say that the good results would be only temporary, as is certainly the case in all true

strictures of the urethra. This is the great point which has yet to be settled, and I offer my cases simply as a contribution to assist in the settlement of the question of the permanent value of this procedure.

With regard to the incision I am distinctly of the opinion that the transverse incision is by far the best, as it enables the surgeon to manipulate the stomach more easily, and in cases of mistaken diagnosis he can at once perform pylorotomy or otherwise indicated.

The day may yet come when it may be advisable for us to excise ulcers of the stomach, and bring together the divided parts. In any future similar case to my second should I discover an ulcer near the pylorus I would certainly make an attempt at complete excision.

DR. MARTEN then read a paper on

CASE OF EXPLORATION OF THE PYLORUS FOR SUPPOSED OBSTRUCTION.

By R. HUMPHREY MARTEN, M.B., B.Ch.,
CANTAB., M.R.C.S., L.R.C.P., LONDON,
HONORARY ASSISTANT SURGEON ADELAIDE
HOSPITAL, SOUTH AUSTRALIA.

THE following case is of great interest in showing how easy it is in spite of the very greatest care to be mistaken in a diagnosis and yet such a good result to accrue from a surgical operation. It is worthy of being put on record notwithstanding no stricture was found, as successes and failures alike must be recorded if any statistics are to be formulated of any value.

My intention was to do a Loreta's operation on the pylorus, but after the reading of the case it will be seen that this was impossible.

The history is as follows: J.F., æt. 47, a railway labourer, born in Pomerania but had lived in Australia for the last 20 years, came under my care in February, 1888, for symptoms which, together with the past history, pointed strongly to a simple pyloric obstruction from the cicatrization of an ulcer. His family history showed that his mother died of phthisis, æt. 45, also one brother at 24. Three brothers are alive and perfectly healthy, but two died during the Austrian war. One of his sisters has a weak chest, but otherwise there is no history of new growths, rheumatism, gout, or other important disease.

Past history shows patient always enjoyed good health till the age of 19, with the exception of measles. He served in the Prussian army without seeing active service for $3\frac{1}{2}$ years from 1866 to 1869.

At the age of 19, when apprenticed to a furniture maker he "strained his inside" whilst lifting a heavy piece of wood; next day he had a sensation of a "weight" at his epigastrium, which lasted for three months, when he vomited a large quantity of bright red blood and fell back fainting on the floor. He was attended by a doctor who ordered him nothing but ice to suck and drew his attention to his tar-like stools; no more bleeding occurred, and he was able to resume his work in 14 days. He was seen during this illness by Professor Eichstadt, of Greifswalde, who told him he had a "sore" in his inside. After this illness patient had pain with his food for a few days, but this soon disappeared.

Quite well till the age of 24, then in an army hospital for a fortnight for gastric pains, but no vomiting or hæmatemesis. Came to Australia in 1870 and worked in the gold mines of Victoria. Quite well for two years, then began to suffer from pain at the epigastrium, relieved by food, then vomiting came on at irregular intervals, sometimes small, sometimes great quantities. At this time he used to physic himself with bicarbonate of potash. He was then an out-patient at the Beechworth Hospital for three weeks and was treated for dyspepsia, but derived no benefit. During 1880 he was under several well-known medical men in Melbourne, who diagnosed carcinoma of the pylorus. Went to the Homœopathic Hospital in Melbourne about this time, and was again treated for pyloric cancer. In 1882 he had typhoid fever. In 1883 he came to South Australia, and for the next three months was either an in or out-door patient at the Adelaide Hospital for attacks of vomiting which came on at irregular intervals, but he derived no benefit from treatment.

He then consulted a private medical man, who washed out his stomach for three months and then taught him how to do this for himself, at this time sarcinæ were present in his vomit. About this time he was operated upon for piles. From the end of 1883 to the time of the operation patient washed out his stomach about once a week, using as a rule eight pints of water before vomiting came on. He has always been extremely careful with his diet, living principally on scraped beef, bread crumbs, and milk. During his whole illness he did not lose much in weight. Whilst he was under my care and prior to the operation, I gave him all the usual stomachic medicines, such as bismuth, pepsin, and the creasote mixture, and although he would improve somewhat for a week or two, he was never free for long together from pain and vomiting.

His present state on July 19 was as follows:—He is a tall, thin, careworn-looking man with

sunken eyes, complaining of weakness, loss of flesh, epigastric pain crampy in character moving about umbilical, epigastric, and both hypochondriac regions, followed by attacks of vomiting, consisting of semi-digested food with a large quantity of frothy fluid; suffers very much from flatulence, and epigastrium often becomes very distended; after vomiting pain is easier, but leaves a sensation of soreness; never had any more attacks of hæmatemesis, but has noticed streaks of blood in vomit; feels a sensation when in bed at night as though water was slowly trickling out of stomach into bowel and air taking its place; generally suffers from constipation unless medicine be taken, and stools are always very small in quantity; vomiting attacks are always less after action of bowels; tongue fairly clean; teeth beginning to decay.

Abdomen.—Walls retracted; ribs standing out; superficial epigastric and circumflex iliac veins distended.

Stomach.—Percussion note extends from level of fifth rib in left nipple line to a hand and a half's breadth below rib cartilages, and is not much influenced by generating C.B. gas in stomach; no peristaltic action to be seen; no swelling to be detected anywhere over stomach or duodenal area; gurgling constantly audible with stethoscope. *Liver* not enlarged.

Vomited matters are acid in reaction, and on standing separate into a superficial floating frothy portion which contains sarcinæ and torulæ under the microscope, but no blood, and a lower greyer portion of semi-digested chyme. *Other organs* are perfectly healthy.

Urine.—Normal colour; acid reaction; no albumen; no sugar; 1019 sp. gr.; patient weighs 142½ lb.

July 19.—Sent into private hospital, South Terrace, and was seen by Drs. Gardner, Giles and Todd, and Professor Watson.

July 21.—Stomach washed out and patient given haust. sennæ co. 3i 4tis horis and an enema saponis at night.

July 22.—Stomach washed out at 7 a.m.; no food allowed by mouth; injection of 3i of brandy and 3iii of warm water into bowel at 8.30 a.m.

Operation at 9 a.m. Professor Watson, Drs. Gardner, Giles, Todd and Swift being present—Dr. Todd giving ether, Dr. Giles helping me, with the assistance of Drs. Gardner and Swift, to all of whom I have to offer my best thanks, especially to Dr. Gardner, who gave me most valuable advice all through from his great practical experience both in gastric and abdominal surgery in general. The abdomen having undergone the usual clearing and washing with carbolic lotion, an incision five inches long, extend-

ing from one inch below and to the left of the xiphoid cartilage to an inch below cartilage of ninth rib, was made, dividing the left rectus abdominis. All vessels having been ligatured, the peritoneum was opened when transverse colon with mesentery presented. This was kept out of the way with a sponge, and the stomach was brought up into the wound. This appeared very vascular and of a bluish-red colour. Sponges having been placed around, an incision about two inches in length in the long axis of the stomach was made with scissors, beginning one inch from the pylorus; finger inserted and passed fairly readily through pylorus and down duodenum for some distance without feeling any evident stricture, and the largest size MacNaughton Jones's dilator readily slipped to the left of the spine without meeting any resistance; pylorus dilated so as to admit two fingers without much trouble or resistance. Walls of stomach were thickened, very vascular, and surface of mucous membrane studded with small granular-looking bodies; mucous membrane sewn up with a continuous silk suture, and then 30 Gussenbauer's sutures of fine silk inserted into wound of stomach, which when tied brought the serous surfaces well together with an extra plain suture at either end; peritoneal cavity washed out with a warm boracic solution, and abdominal wound treated in the ordinary way; wound dressed with iodoform and salicylic wool; operation lasted one hour and 20 minutes; very little stool; vomited twice after ether, bringing up 3ii of bloody frothy slime.

From this time patient made an uninterrupted recovery, having nothing by the mouth but ice to suck, and being fed by nutrient enemata every four hours from the operation till the fifth day, July 27, when he was allowed some jelly by the mouth, which caused no ill effects. Next day, July 28, he had some bread and milk. On August 1, ninth day from operation, he was allowed fish, an egg and bread and butter, with no ill results. On August 4 all stitches taken out. Got up on 5th, i.e., 14 days from operation, and had a chop for dinner without any inconvenience.

August 12.—Weighs 140 lbs., a loss of 2½ since operation. Takes ordinary full diet, no pain, sometimes a little flatulence. Bowels act every day with the help of arsenia jujubes. Left to-day for the country.

September 18.—Returned to-day to town, looks and feels exceedingly well and strong. Eats anything except pork, pastry and cheese. Now and then suffers from flatulence, never been sick since ether vomiting. Weighs 154½ lbs., a gain of 14½ lbs. in 39 days.

October 19.—Patient came to-day complaining of a little weakness at the scar, otherwise eats

well and has no pain to speak of, no flatulence, no nausea, or vomiting. Follows his usual employment as a railway permanent way man. Weighs 158½ lbs., a gain of 18½ lbs. since August 5.

From the history and the symptoms this patient presented I felt pretty sure that it was a case of cicatricial contraction of the pylorus, and in this view the medical men who saw the case with me concurred, and strongly recommended Loreta's operation, which I had commenced to do when I came upon a fairly patent pylorus, which certainly ought to have allowed all ordinary food to pass through it, and only shows how easy it is to go astray in a diagnosis. The late Professor Loreta points out that the diagnosis has to be made between cancer, fibrous stricture, and idiopathic gastritis. Cancer could be excluded in my case by the 19 years history and the absence of any tumour. The difficulty was between stricture and idiopathic gastritis, and Loreta gives rules as to deciding which of the two is present; he says that if the vomited matters be carefully examined, in stricture the lower layers will consist of acid chyme, well digested, as it did in my case, whereas in gastritis it is undigested food and little chyme, and in the former case a longing for food, in the latter a loathing. Everything seemed to point to a stricture, but this could not be when the finger so easily slips through the pylorus, and the peculiar granular appearance of the inside of the stomach points more to idiopathic gastritis. The question is, how did the operation cure the patient? as it certainly seems to have done.

The only way I can see of explaining it is either that the incision acted as a strong counter-irritant to the walls of the stomach, which evidently from their appearance were suffering from a chronic gastritis, together with the rest the stomach had for five days when nothing was given by the mouth, brought about a healthier condition of the mucous membrane and so allowed the food to digest properly. I think giving solid food early and pushing it instead of giving slops goes a long way towards improving the stomach.

Another reason for such marked improvement is that a sort of spasmodic contraction occurred at the pylorus similar to what we know occurs at the anus and which was cured by the stretching.

A discussion followed in which Drs. Thomas, Corbin, Gardner, A. A. Hamilton, and Lendon joined.

BURBROUGH'S POCKET MEDICAL DIARIES FOR 1890, with which is combined a *Materia Medica* and other matter up to date will arrive shortly. This diary is sent out in two forms—(1) bound in leather with tuck, price 4s., and (2) in silk and enclosed in pig skin leather case, with pockets for cards, stamps, &c., price 5s. 6d. Postage 3d. extra. Orders are now being booked by L. Bruck, 13 Castlereagh-street, Sydney.

NOTICE.

The Editor will feel obliged by any gentleman, who wishes to ventilate any subject of professional or public interest, writing an editorial or leading article on it, which if found on perusal to be consonant with the policy of the paper, will be inserted in an early number.

All communications intended for the Editor should be sent to the 'A. M. Gazette' Office, 35 Castlereagh Street, Sydney.

** * Contributors can have their Papers reprinted and published in Pamphlet form, at Cost Price, if the necessary instructions are given to the Publisher at the same time the contributions are sent in.*

AUSTRALASIAN MEDICAL GAZETTE.

SYDNEY, NOVEMBER 15, 1889.

EDITORIALS.

MEDICAL ETIQUETTE IN AUSTRALIA.

OTHER professions have unions or are such close boroughs that it amounts to union, nay, the very merchant seamen are in this a standing reproach to us, and were medical men one-tenth as united as the members of the Seamen's Union they would individually be gainers, and the public generally have greater reason to repose confidence in us as a body. Can everyone of us say we have never unduly hinted that a confrère was wrong in his diagnosis or treatment? Have we never suggested that a case would recover if left to our mighty selves? Are we always insisting upon strict etiquette in seeing a brother practitioner's patient? Do we always avoid increasing our own practice at the expense of a perchance absent brother? We are afraid very few can answer such questions in the affirmative.

It must be granted that practice in Australia is very different to that of the old country, and the rule which obtains there of families always employing the same medical man is to a great extent reversed here, the prevalent idea of giving everybody a turn holding good for the doctor and the baker alike. This being so, it is only reasonable to suppose that many breaches of professional etiquette are inadvertent. Still the fact remains that we are sadly deficient in this matter. Take the up-country towns where there are two medical men, in how many will you find these two friendly? What Dr. A. tells his patients will cure them, Dr. B. is equally assertive that such treatment will hurry them to an early grave. Should a consultation be necessary Dr. B. is very

sorry but he does not meet Dr. A. But should Dr. C. come and start practice then old feuds are forgotten, and A. plus B. are greater than C.; indeed this may be prolonged *ad infinitum* as the town increases in size. Clubs do much to create and keep warm jealousies between rival practitioners, for the one who does not succeed in getting them is sure to dub his opponent the club doctor, and equally sure to profess that he would not take such low class practice. Clubs are neither things of beauty nor are they joys for ever to the man who takes them, we know not but possibly they do lower his keen sense of honor but we do know that professional fellow-feeling is dulled by their existence. For who amongst us hesitates to treat a case which he knows is a club case without consultation with the club doctor? Indeed, we rather pride ourselves that we are doing him a good turn since he will not pecuniarily suffer, nor will he have the trouble of looking after the case. Still there remains somehow a vague notion that this is not quite right.

Next let us take the larger towns where there are, say, eight to a dozen or so practitioners. Outwardly there is a certain amount of *esprit de corps*, in fact we have a larger gallery to play to, and we do it. We do not knowingly attend another's patient whilst that other is in actual attendance, but should the patient wish to change he can dispense with such other's services, in which event we are happy to take charge. Then, of course, there is the hospital—for all towns of this size have a hospital, and those who comprise its professional staff are of necessity likely to form a clique for their own advantage. But the jealousies which arise from this source are rather of a healthy nature, and likely to benefit the public, since they derive their being from a sense of emulation, rather than pure selfishness. Unfortunately, however, these jealousies do not always stop at this point, and we can call to mind many other instances of strange doings by brother professionals to Resident Surgeons of hospitals, and *vice versa*. One gentleman (save the mark) wrote a letter, intended for a Resident Surgeon's successor, in which he stated that he had told the patient not to see Dr. D., who was leaving, but Dr. F., who was taking charge, as Dr. D. was an ignorant quack. Yet Dr. D. possessed superior qualifications to this self-constituted judge, and is at the present time better known in the profession than the "gentleman" ever was, or ever can be. Another instance: X succeeds Z as Resident Surgeon of a large hospital; X disagrees with some treatment of Z, and alters it; this upsets Z's *amour propre*, and he proceeds to undermine X's general management, and to persuade the committee of the institution to find fault; finally

he succeeds in getting charges brought against X, which result in his dismissal, although the proof is but slender, and resting on a disputed point of treatment. Having done this, by his personal influence he induces the committee to appoint a friend. This may not be professional etiquette, but it is true; the same "gentleman" has on more than one occasion, whilst at the club, chaffed his patients openly, asking them how their venereal disease progressed.

In the Australian capitals, happily, brotherly conduct is not at a discount in the profession, still even in them, occasional breaches of etiquette are deliberately perpetrated by those who should be above such things.

Consultants abound, and no doubt are essential, but do they *never* pooh-pooh a country practitioner's idea? Do they never suggest that the great I should have been consulted sooner? Very probably in both circumstances they may be speaking the truth, but is it not very largely commingled with self-laudation? Would they say all they do to patients, unless they wished to produce the impression that they only are the competent persons to treat such cases?

The question of advertising must always play an important part when considering what *is*, and what is *not* professional etiquette. That it exists is only too patent, and that it should cease to do so is equally clear, unless, of course, we all open shops, in which case one would expect to see such advertisements as drapers or other tradespeople produce. It would certainly be amusing were it not derogatory to read—

"Dr. ——. A very cheap line in Gonorrhoea and other venereal diseases.

Dr. ——. This house long established, makes children's diseases a speciality, and is excelled by no other house in Sydney or Melbourne for carefulness of work and the quality of medicines given. A trial solicited.

Dr. ——. Visitors to Sydney are invited to inspect a large and varied collection of liver pills now on view at Dr. —'s. These are the finest modern collection of remedies, and are offered to the public at purely commercial prices."

Indeed this style might be indefinitely added to; but what we want to point out is that some at least of the advertisements of qualified men are of this nature, and while they exist can we say we have any sense of the dignity due to our profession? Such would not be tolerated for one moment in the old country, and it is to our disgrace that we permit it here. Its source is to be traced to the unblushing notices of quacks and their advertisements, by which the daily papers throughout the colonies puff up so-called specialists and patent medicines, to the debasement of

properly qualified men, since the latter, to a certain extent in self defence, are compelled to advertise. Another cause of its existence is the registration of inferior diplomas which was by no means uncommon.

Lastly, have we a means of remedy for all these things? At present we have not, and it is for the purpose of pointing one out that this article is written. We have already in a previous number shewn that benefit would be derived from federation as regards registration, we now go a step further and would urge that a Federal Medical Council be appointed who shall possess the power not only to register properly qualified men, but to remove such names from the register for unprofessional conduct or advertising. In short, a body similar to the Medical Council of Great Britain but with increased local power. This Australian Medical Council would naturally have representatives in every capital who would investigate local cases and report to the whole body. Not only could registration be carried on by this council, but other functions, such as the arrangement of quarantine, could be discussed and instructions given in case of infectious disease appearing in our midst. We possess Medical Boards in each colony, is there any reason why these should not federate even if only for the example of union between professional men? Separately, they are of some small use, but united they might become an important factor to control disease and its treatment, and to compel those, whose mission in life is to battle against "the ill that flesh is heir to," to observe towards each other that brotherly feeling and etiquette which of right belongs to a noble and honourable profession.

THE APPOINTMENT OF POLICE SURGEON IN VICTORIA.

IN making the appointment of Surgeon to the Police in Melbourne the Chief-Secretary has made a new departure which, we think, is a great advance on the ordinary way of making Government Medical appointments in Australia. For this post—the remuneration for which is £400 per annum, with the addition of some special fees—there were forty applicants. These applications were referred to a committee of three medical men: Drs. McCrea, the late, Dr. Shields, the present principal Medical Officer, and Dr. Dick, Inspector of Asylums, who were requested to examine into the qualifications, professional and otherwise, of the numerous applicants, and to choose from them the three most eligible candi-

dates for the guidance of the Chief-Secretary, who from them selected Dr. G. A. Syme. By this course of procedure the political pressure which would otherwise have been brought to bear was avoided, a pressure which it is so difficult for a Minister, however conscientiously desirous of making the best appointment, to avoid sometimes yielding to. We have in our mind's eye more than one medical appointment which has been made in the various colonies in which a very inferior man to other applicants has been appointed, as a consequence of the political pressure he was able to bring to bear upon the Minister by means of more or less ignorant partisan friends, who chanced to be members of the Assembly. In this way good men are discouraged, the people who are to be professionally attended to are less well-served, whilst inferior practitioners are unduly exalted, and become too great for the mental ballast they carry.

LETTERS TO THE EDITOR.

VOLKMANN'S METHOD FOR ECHINOCOCCUS OF LIVER.

(To the Editor of the A. M. Gazette.)

SIR,—In the issue of the *Australasian Medical Gazette* for October, 1889, there appeared an article from the pen of Dr. J. B. Ross, of Macarthur, Victoria. In it he asserts the superiority of Von Volkmann's operation for echinococcus of the liver over that of Lindemann. The latter was strongly advocated at the late Medical Congress in Melbourne by myself and also by my colleague, Dr. Gardner, of Adelaide.

Dr. Ross is not satisfied that the evidence then adduced in detail is conclusive. This must be left to the decision of the general mass of the medical profession throughout these colonies, where the disease is so common, but not less is it a question of world-wide interest and importance. The main points in Dr. Ross's criticisms appear to me to be:—

1. "The general practitioner is as a rule devoid of that operative dexterity absolutely necessary for such operations (i.e., as Lindemann's), whereas Von Volkmann's method is just adapted for the universal use of the general practitioner who is called upon to operate where skilled assistance is not available."

2. Dr. Ross objects to my published statistics of Von Volkmann's operation, inasmuch as cases treated without formal antiseptics are included with those treated according to more modern methods.

I propose, with your permission, to reply to these allegations.

1. As to the statement that greater operative skill is required for Lindemann's procedure, I here join issue with Dr. Ross, for I fail to see in what respect this need of greater expertness is needed; the operations are both extremely easy of performance.

2. With regard to the table of results published by me and alluded to by Dr. Ross in connection with Von Volkmann's operation (see *Australian Medical Journal*, June 15, 1889, pages 243-245), there is a certain amount of warranty for the objections of the critic, but a reference to the table in question will show that

as a matter of fact the cases treated in the pre-antiseptic period do not compare unfavourably with the more modern operations of this class; and in preparing my tables it seemed to me that it was unnecessary to classify separately such similar procedures, especially as no practical injustice was done by taking them together.

But of greater significance in this connection than mere numerical evidence is the record of a case treated by Volkmann's method and reported in *The Lancet* of September 21, 1889, page 595.

The patient was under the care of the late Professor Moses Gunn at the Presbyterian Hospital, Chicago. Volkmann's operation for hydatid of the liver was here performed, the primary incision being carried down to "the internal fascia of the internal rectus abdominis muscle." The incision was then packed with iodoform gauze, "aiming thereby to excite inflammatory adhesion of the peritoneum." "A week later (July 19) the packing was removed, but no evidence of adhesion was found." The operation was prudently completed by Lindemann's method.

This case conclusively proves to me that a wound immediately adjacent to the peritoneum may be plugged for a week without causing the production of adhesions. I do not assert that if the peritoneum had been opened the result would have been equally futile, but I see no valid reason for taking a week to ensure this condition in ordinary cases of laparotomy in liver hydatids; moreover if Lindemann's operation be performed the entire mother-cyst, any existing daughter-cysts, and the hydatid fluid ought to be removed at the time of the operation itself. In this way alone can perfect asepticism be maintained.

I confess that I am surprised at a statement made by Dr. Ross relative to the difficulty he met with in separating the mother-cyst from the fibrous capsule. I have never known of an instance of any organic connection between these structures. Surely the capsule was not mistaken for the parasite? If so, I can quite understand the difficulty of the task.

I am, sir, your obedient servant,

J. DAVIES THOMAS,

M.D. Lond., F.R.C.S. Eng.

Adelaide, November, 1889.

(To the Editor of the *A.M. Gazette*.)

SIR,—I have read with great interest Dr. J. B. Ross' article on Von Volkmann's method for Echinococcus of Liver in the October number of the *Gazette*. The author states that: "The intention of these notes is to prove that Von Volkmann's method is just adapted for the universal use of the general practitioner who is called upon to operate where skilled assistance is not available."

Apart that in the two cases reported by Dr. Ross skilled assistance was actually used in both and was absolutely necessary in one, the history of the said cases prove to my mind that the said method is anything but "just adapted for the universal use of the general practitioner." Permit me therefore to bring under the notice of your readers one such method, viz., Professor Baccelli's. He with a Pravaz syringe draws about ten grains of fluid from the cyst and substitutes to it an equal volume of a sublimate solution containing 1.5 centigrammes of the said substance. The results in the cases reported were always brilliant in five days. The death of the accephalocyst is lightning-like and is followed by symptomatic reactions of slight degree, not to be feared, also by polyuria.

V. MARANO, M.D.

Hyde Park, Sydney.

(To the Editor of the *A. M. Gazette*.)

SIR.—Dr. Ross, of Victoria, in your issue of October, 1889, has recommended to the general practitioner Von Volkmann's operation for Hydatid of the Liver as a safe and absolutely successful method of operating. I agree with him that this method is the best for cases of bulging cysts, which have to be operated on by surgeons who have not skilled assistance; but unfortunately a great many of the cysts we have to operate on are not bulging ones, and have to be sought for after traversing a considerable portion of liver tissue, and their position has to be determined by the insertion of an aspirator needle, and after flowing a little the fluid begins to pass by the side of the needle, and thus is introduced a very dangerous element into the case, viz., the escape of hydatid fluid into the peritoneal cavity. If any fluid escapes by the side of the needle it is much safer to make a free incision and let the whole escape, as the intra-cystic pressure drives the fluid far away from the cyst and there is no dribbling into the peritoneal cavity, especially if, as is always done by my assistant, a circle of sponges keeps the abdominal wall well pressed against the cyst. Before the pressure becomes so slight as to allow of dribbling, the operator can easily have four stitches inserted into the cyst and through the abdominal walls, and handed to assistants, and thus the cyst is kept firmly applied to the abdominal walls, the stitches can be tied at leisure. Another argument against this method is that it has been distinctly proved that adhesions frequently fail to form as is expected, and then Lindemann's operation has to be performed after all.

Lastly, it is quite possible for the intestine to bulge into the wound before adhesions form, the consequence of which would be disastrous, especially as the dressings would be very infrequent if adhesions were desired. The ideal operation consists in attachment of the peritoneum to the cyst before opening by a circle of stitches, but, as is frequently the case, this cannot be done on account of thinness of the capsule. Then, I maintain, that the next best operation, in all cases, is incision through the peritoneum, passing in a fine needle with indiarubber tube attached, till fluid begins to flow by its side, then free incision and hooking the finger in quickly and inserting the four cardinal loops. The rest of the operation may be completed slowly, and far-and-away the most important matter is provided for, viz.: the removal of the whole contents of the sac at one sitting. The mother-cyst never has any organic connection with the external envelope.

Your obedient servant,

WM. GARDNER.

Adelaide, November, 1889.

WE have been requested to call the attention of our readers to an advertisement in our columns of Mrs. W. E. Lewellin, who has opened a Home for Invalids at "Talbot," 119 Victoria-street North, Darlinghurst (Sydney), for the convenience of patients who require proper nursing and wish to be treated by their own medical attendants; references permitted—Dr. Fiaschi and Dr. W. E. Warren.

TO THE MEDICAL PROFESSION.—A rare opportunity now offers to secure one of the most central and eligible positions in Sydney, for one or two Medical Practitioners, situated 269 Elizabeth-street, Hyde Park, within easy access from all parts of the city and suburbs. The house contains eight rooms, kitchen, bathroom, cellars, balcony, side entrance, and every convenience, having undergoing extensive alterations and repairs, is now ready for occupancy. For terms, &c., apply
MEDICUS, *A. M. Gazette* Office.

THE MONTH.

NEW SOUTH WALES.

A resident surgeon is required for the Bathurst Hospital; salary £250 per annum. Applications, with copies of testimonials, must be sent to the secretary, Mr. S. N. Lane, before the 28th inst.

DR. G. W. BAKER has removed from North Waratah (Newcastle) to Raymond Terrace.

MR. ISIDORE MAURICE BLAKE, J.P., M.R.C.S. Eng., 1839, late of Yass, an old colonist of 48 years standing, died at Grenfell on November 1, in his 73rd year.

DRES. A. C. BROWNLESS, P. MCNEILL and R. VANDELEUR KELLY acted as judges at the baby show recently held in Sydney.

DR. G. C. CORY has commenced practice at Moruya, 200 miles S. of Sydney.

DR. A. J. HOOD, late of Maclean, has succeeded to the practice of Dr. H. W. Jackson at Phillip-street, Sydney.

DR. J. MCGINNESS, late of Rochester (Vic.), has settled at Tibobourra, near the South Australian border.

DR. W. O. MAHER returned to the colony by the P. and O. R.M.S. "Rome," and has resumed practice as an oculist at 20 College-street, Hyde Park, Sydney.

DR. J. B. MOORE has resigned the position of Resident Surgeon to the Bathurst Hospital.

DR. H. G. S. WARREN, on his departure from Dubbo, has been presented with an illuminated address by the Oddfellows.

NEW ZEALAND.

At the September meeting of the Canterbury Branch of the N.Z. Medical Association the subject of anaesthetics came up for discussion, and it was decided to adopt as a general guide the series of resolutions which were passed by the N. S. Wales Branch of the B.M.A. in February last and published in the March number of the *A. M. Gazette*.

DR. C. H. HAINES has returned to Auckland from his trip to England.

DR. W. MORRIS, a new arrival from Germany, has commenced practice at Pleasant Point, 13 miles from Timaru, in Canterbury.

DR. W. STEWART has removed from Woodville (Hawke's Bay) to Oamaru, 78 miles N. of Dunedin.

QUEENSLAND.

THE new hospital buildings at Gympie are now completed.

DR. A. B. BROCKWAY has succeeded to the practice of Dr. Wilkie at Muttaborra, 850 miles N.W. of Brisbane.

DR. J. E. ST. G. QUEELY, late of Maytown, has settled at Esk, 70 miles S.W. of Brisbane.

DR. L. REDMOND, formerly of Charters Towers, has just returned to the colony from his trip to the old country, and resumed practice at Charters Towers as ophthalmic, aural, naso-pharyngeal and laryngeal surgeon.

DR. T. H. STRANGMAN has commenced practice at Limestone, a rising township in the Palmer Goldfields District, 30 miles from Maytown; he has also been appointed Surgeon of the newly-established local hospital.

SOUTH AUSTRALIA.

In the Legislative Assembly on October 22, the Hon. J. H. Gordon, Minister of Education, introduced a Bill to amend the Medical Act of 1880; the Bill was read a second time on November 5.

THE total number of in-patients admitted into the Adelaide Children's Hospital for the year ended September 30 was 310, of whom 186 were discharged cured, 59 relieved, 17 unrelieved, 12 deaths, and 36 remained in hospital on 30th September. The admissions to the hospital from its commencement to September 30 of the present year numbered 2,236. The attendances at the outdoor dispensary during the year numbered 2,325, making a total of 35,023 from the founding of the hospital.

NINE cases of typhoid occurred at Quorn lately, which proved fatal in two instances.

DRES. O'CONNELL, HENRY and R. ROBERTSON acted as judges at the late baby show in Adelaide.

DR. P. J. W. TERNAN, of Burrundie, has been appointed Assistant Health Officer for the Northern Territory.

TASMANIA.

MR. JAMES RICHARDSON, registered in the colony by "Letters Testimonial," died at Launceston last month; the deceased gentleman, for a great many years past, held the positions of Police Magistrate, Vaccinator, Health Officer and Coroner at Georgetown, at the mouth of the river Tamar.

DR. H. A. REED, late of Caulfield (Vic.) has settled at Hamilton.

VICTORIA.

THE Annual Dinner of the Medical Society of Victoria was held in the Melbourne Town Hall on November 6. Dr. Balls-Headley, the president of the Society, occupied the chair, and there was a large number of members present.

MR. JAMES MATTHEWS NOLAN, L. et L. Med. R.C.S. Irel. 1862, who has been practising at Beauport for five years, was found dead in his room on Sunday morning, October 6. He had been ailing for some time, but was apparently in good health on Saturday night.

DR. T. ELMES, of Berwick, has been appointed Superintendent of the temporary Asylum for Inebriates at Beaconsfield.

DR. J. F. MERRILLES, of Auburn (Melbourne), has removed to Kyabram, 145 miles from Melbourne.

DR. J. E. J. MOFFITT, formerly House Surgeon at the Sydney Infirmary, and late of Broken Hill, has been appointed Resident Surgeon to the Creswick Hospital; there were only eight applicants for the position.

DR. C. H. MOLLOY, Acting Medical Superintendent of the Melbourne Hospital, has been permanently elected to the position at a salary of £500 per annum.

DR. HY. NICHOL, of Bendoc, has been appointed a Justice of the Peace.

DR. D. P. O'FARRELL, formerly of St. Peters, Sydney, has commenced practice at Toongabbie, 109 miles from Melbourne.

DR. JOS. ROSS has removed from Macarthur to Warrnambool.

DR. S. V. THEED has commenced practice at Mornington, a watering place 33 miles south of Melbourne.

DR. SAMUEL WILSON, late of Belfast (Ireland), has settled at Phillip Island.

MEDICAL APPOINTMENTS.

Baird, John Chalmers, M.B. & Ch.B. Melb., to be Health Officer for shire of Healesville, Vic.
 Carolan, James Frederick, M.R.C.S.E., to be Public Vaccinator for the district of Waiwera, N.Z.
 Catlan, William James, M.B. & Ch.M. Edin., to be Public Vaccinator for the district of West Tairā, N.Z.
 Kadon, Samuel Bailey, M.D. & Ch.M. Aberd., to be Public Vaccinator at Tallygaroopna, Vic.
 Evans, John Herbert, M.B. & Ch.B. Melb., to be a Public Vaccinator in South Australia.
 Haines, Hugh Gough, F.R.C.S. Ed., to be Government Medical Officer for the district of Longford, Tas.
 Merrilees, James Frederick, M.B. Melb., to be Public Vaccinator at Kyabram, Vic.
 O'Farrell, Denis Paul, L.R.C.S. Irel.; L.K.Q.C.P. Irel., to be Public Vaccinator at Toongabbie, Vic.
 Paton, Robert Thomson, F.R.C.S. Ed.; L.R.C.P. Ed., to be Government Medical Officer and Public Vaccinator for the district of Trial Bay, N.S.W.
 Robinson, Leonard, M.D. & Ch.M. Roy. Univ. Irel., to be Public Vaccinator at Hamilton, Vic.
 Ross, John, M.B. & Ch.M. Ed., to be Public Vaccinator for the district of Waioa, N.Z.
 Stewart, William, M.D. Glas., L.R.C.P. Lond., L.R.C.S. Ed., to be an additional Vaccinator for the district of Oamaru, N.Z.
 Wilson, Samuel, M.D. & Ch.M. Roy. Univ. Irel., to be Health Officer for shire of Phillip Island, Vic., vice Dr. C. W. Rohner.

BIRTHS, MARRIAGES AND DEATHS.

. The charge for inserting announcements of Births, Marriages, and Deaths is 2s. 6d., which should be forwarded in stamps with the announcement.

BIRTHS.

DAVIES.—On the second October, at Benalla, Victoria, the wife of Dr. T. Sydney Davies, of a daughter.
 DRUITT.—October 30, at Wagga Wagga, N.S.W., the wife of Dr. L. Drutt, of a daughter.
 FORSTER.—On the 2nd November, at Albert-park, South Melbourne, the wife of Dr. H. B. Forster, of a daughter.
 LEMPIERE.—On the 15th October, at South Yarra, Melbourne, the wife of C. L. Lempriere, M.B., C.M., of a daughter.
 RENNIE.—October 12, at 129 Phillip-street, Sydney, the wife of George R. Rennie, M.D., Lond., of a son.
 SYME.—On the 8th October, at Stawell, Victoria, the wife of W. H. Syme, surgeon, of a son.

MARRIAGES.

BEAN—HARKER.—On the 2nd October, at the Albert-street Baptist Church, Harold Knowles Bean, M.D., B.Sc., of Heidelberg, Victoria, to Lucy J., eldest daughter of the late Calvert Harker, of Alexandria.
 MOORE—MOORE.—October 11, at St. Paul's Church, Bockhampton, Queensland, by the Rev. John Hunt, John Irwin Moore, L.R.C.S.I., L. & L.M.K. & Q.C.P.I., Springsure, to Susan, daughter of Thomas Charles Moore, Grosvenor Square, Dublin.
 POULTON—TEASDEL.—On the 17th October, at St. Matthew's, Marratville, South Australia, Benjamin Poulton, M.D., of North-terrace, Adelaide, to Lettice Cordella, only daughter of Frederic Teasdel, of Marratville.
 ROBINSON—CLARKE.—On the 25th September, by the Rev. J. S. Drummond, Archibald Clarke Robinson, M.D., L.R.C.S. Ed., of Jerilderie, N.S.W., to Edith Kathleen, third daughter of John Clarke, Emu Hill, Linton.
 THWAITES—PATON.—On the 3rd October, by the Rev. J. Patterson, Johnstone S. Thwaites, M.B. & B.S., of Tallangatta, Victoria, to Katie, eldest daughter of Archd. Paton, Yabba, Victoria.
 TRINDALL—WARREN.—August 31, 1889, at St. Barnabas' Church, Sydney, Richard B. Trindall, B.A., M.B. Ch.M., of Helensburgh, N.S.W., to Rosina, only daughter of the late Thomas Warren, Kingston, Sydney.
 GRAY—SMITH.—On the 23rd October, at St. John's Church, Toorak, Melbourne, Thomas Gray, M.B. Ed., New Norfolk, Tasmania, to Edith Margaret, fourth daughter of the late Captain Alexander John Smith, R.N., Langley, Victoria.

DEATHS.

BOYD.—On the 16th October, at View Point, Sandhurst, Victoria, Annie, wife of James Boyd, M.D.
 FLETCHER.—On the 29th October, at Carlton, Melbourne, Emma, wife of Dr. B. Fletcher, aged 60 years.
 THOMSON.—On the 24th October, at South Yarra, Melbourne, Emilie Kate, wife of Dr. M. Barclay Thomson, in her 35th year.

BOWRAL.—Dr. Wilson has superior accommodation for medical boarders.

PROCEEDINGS OF COLONIAL MEDICAL BOARDS.

The following gentlemen, having presented their diplomas, have been duly registered as legally qualified Medical Practitioners by the respective Boards:—

NEW SOUTH WALES.

Samuelson, Gerald Septimus, M.B. & M.S. Edin., 1888.
 Champ, John Howard, M.D. Lond., 1884; L.S.A. Lond., 1887; M.R.C.S. Eng., 1883.
 Reid, John, M.B. & M.S. Aberd., 1882.
 Camac, Samuel Jones, L.R.C.S. Edin., 1884; L.R.C.P. Edin., 1884.
 Anderson, James Robert, L.R.C.P. Lond., 1889; M.R.C.S. Eng., 1889.

NEW ZEALAND.

Morris, Wilhelm, M.D. Erlangen, 1888; Certif. State's Exam., Munich.
 Palmer, Robert, M.B. & Ch.M. 1873; M.D. 1876, Ed.

QUEENSLAND.

Brockway, Archibald Birt, M.R.C.S. Eng., 1887.
 Camac, Samuel Jones, L.R.C.P. & R.C.S. Edin., 1884.
 Egan, John Joseph.
 Turner, Alfred Jeffers, M.B. 1884, M.D. 1886, Lond; M.R.C.S. Eng. 1884.

TASMANIA.

Harrison, William Atkinson, M.B. & Ch.M. Ed., 1880.

VICTORIA.

Webster, George Alexander, M.R.C.S. Eng., 1886; M.B. Camb., 1889.
 Denning, John Vere Charles, L. & L. Mid., K.Q.C.P. Irel., 1871; L.R.C.S., Irel., 1871.

WESTERN AUSTRALIA.

Harvey, Henry Frederick, M.R.C.S. Eng., L.S.A. Lond., 1876.

PUBLICATIONS RECEIVED.

Report of the Board of Technical Education of N.S.W. for 1888; and Calendar of Sydney Technical College, for 1889.

De la lobéline dans la Thérapeutique de l'Asthme. Par le Dr. Silva Nunes: Rio de Janeiro, 1889.

Strathpeffer Spa, its Climate and Waters. By Fortescue Fox, M.D., (Lond). London: H. K. Lewis, 1889.

Examination of Water for Sanitary and Technical Purposes. By Henry Leffmann, M.D., Ph.D., and Wm. Beam, M.A. Philadelphia: P. Blakiston, Son, & Co., 1889.

Merck's Index of fine Chemicals and Drugs. 1889.

Catalogue of the Scientific Serial Literature in the Principal Libraries in Sydney. Compiled under the direction of Professor T. P. Anderson Stuart. Sydney: Charles Potter, Government Printer, 1888.

Hygiene and Public Health. By Louis C. Parkes, M.D., D.P.H. London Univ. illus., 1889.

What to do in Cases of Poisoning. By Wm. Murrell, M.D., F.R.C.P.; 6th ed., 1889.

Notes on the Electro-Magnet in Ophthalmology, with a Report of nine cases. By Wm. Ellery Briggs, M.D. Sacramento, California: Reprinted from the *Occidental Medical Times*, August, 1889.

Ether as an Anæsthetic. By Isaiah de Zouche, M.D. Dunedin.

Burroughs, Wellcome, & Co.'s A.B.C. Medical Diary for 1890, with which is combined a *Materia Medica*, and other matter up to date, in silk, and enclosed in pig-skin letter-case, with pockets for cards, stamps, &c.

DOCTOR'S SON would be glad to employ his evenings in keeping accounts for medical men. Address—C. B., 85 Redfern-street, Redfern.

MR. BRUCK has received a full supply of *Pollock and Chisholm's Medical Handbook for Life Assurance* (price 7s. 6d., postage 6d.), also a large number of other recent publications—*vide* book-list in this issue.

REPORTED MORTALITY FOR THE MONTH OF SEPTEMBER, 1889.

Cities and Districts.	Population.	Births Registered.	Deaths Registered.	Deaths under Five Years.	Number of Deaths from									
					Measles.	Scarlet Fever.	Croup and Diphtheria.	Whooping Cough.	Typhoid Fever.	Dysentery and Diarrhoea.	Phthisis.	Heart Disease.	Cancer.	Child-bearing.
N. S. WALES.														
Sydney	132,846	280	151	51	...	1	5	3	2	2	7	8	5	2
Suburbs	215,849	788	243	95	...	1	14	6	3	5	29	17	6	2
NEW ZEALAND.														
Auckland	35,858	69	22	1	...	...	...	...	...	...	6	3	...	...
Christchurch ..	16,455	30	12	4	...	...	...	...	1	...	1	2	...	...
Dunedin	23,546	48	23	8	...	...	...	...	...	...	5	4	1	...
Wellington	29,075	65	31	12	...	..	...	...	...	...	4	2	3	...
QUEENSLAND.														
Brisbane	51,689	178	85	42	}	...	2	5	3	11	15	4	3	1
Suburbs	21,960	130	34	20	
SOUTH AUSTRALIA	316,134	878	247	76	...	...	12	...	2	2	24	20	11	7
Adelaide	43,750	80	61	15	...	...	2	...	2	1	7	4	5	1
TASMANIA.														
Hobart	34,792	101	50	9	...	...	...	1	4	...	4	2	3	...
Launceston	21,448	64	35	7	...	...	1	...	...	...	2	5	...	...
Country Districts	91,780	...	...	...	...	...	...	...	...	...	...	...	...	...
VICTORIA.														
Melbourne	75,400	170	95	} 222	...	3	44	22	6	8	67	51	30	7
Suburbs	362,385	1282	547											

METEOROLOGICAL OBSERVATIONS FOR SEPTEMBER, 1889.

STATIONS.	THERMOMETER.					Mean Height of Barometer.	RAIN.		Mean Humidity.	Prevailing Wind.
	Maximum Sun.	Maximum Shade.	Mean Shade.	Minimum Shade.			Depth.	Days.		
							Inches			
Adelaide—Lat. 34° 55' 33" S.; Long. 138° 36' E. ....	...	76.7	55.2	38.5	29.914	...	...	...	...	...
Auckland—Lat. 36° 50' 1" S.; Long. 174° 49' 2" E.	130.7	71.1	56.6	44.1	...	5.320	19	80	...	...
Brisbane—Lat. 27° 28' 3" S.; Long. 153° 16' 15" E.	142.8	85.7	65.1	45.5	30.060	3.307	10	71	s.	...
Christchurch—Lat. 43° 32' 16" S.; Long. 172° 38' 59" E.	132.8	69.2	48.7	31.8	...	3.665	12	79	...	...
Dunedin—Lat. 45° 52' 11" S.; Long. 170° 31' 11" E.	110.7	63.1	47.9	35.1	...	1.760	12	79	...	...
Hobart—Lat. 42° 53' 32" S.; Long. 147° 22' 20" E. ....	...	70.2	49.9	33.7	29.880	1.13	16	74	...	...
Launceston—Lat. 41° 30' S.; Long. 147° 14' E. ....	...	66.1	51.2	31.1	29.959	3.55	12	80	...	...
Melbourne—Lat. 37° 49' 54" S.; Long. 144° 58' 42" E. ....	...	74.5	52.3	32.1	29.937	1.51	14	...	...	...
Sydney—Lat. 33° 51' 41" S.; Long. 151° 11' 49" E. ....	...	83.7	57.4	44.1	30.053	4.33	19	69	w.	...
Wellington—Lat. 41° 16' 25" S.; Long. 174° 47' 25" E.	130.7	65.5	53.1	39.1	...	4.780	17	77	...	...

AUSTRALASIAN MEDICAL GAZETTE.

ORIGINAL ARTICLES.

TRACHEOTOMY IN DIPHTHERIA—ITS AFTER TREATMENT.

READ AT THE MEDICAL SECTION OF THE ROYAL
SOCIETY OF N. S. WALES.

By C. P. B. CLUBBE, L.R.C.P. LONDON, M.R.
C.S.E., HON. ASSISTANT SURGEON PRINCE
ALFRED HOSPITAL, HON. SURGEON SICK
CHILDREN'S HOSPITAL, SYDNEY.

DURING a period of six weeks, from the middle of June to the end of July of this year, 1889, I had six cases of diphtheria under my care which required tracheotomy. Of these six children, five recovered and one died. Four cases were in the Children's Hospital, and two in my private practice.

Three of the children were six years old, one was four years, one three years, and the one that died was two years old.

Dr. Garrett, the house surgeon, operated on one of the children at the hospital for me, as at the time I had a sore finger, but I was present and gave the anæsthetic, and saw the child frequently afterwards.

The hospital cases were all operated on very soon after admission. One of these cases I saw with Dr. West, in the Glebe, before admission. As the case was very urgent, although the parents were well to do, we decided to send it to the hospital, especially as there was no suitable room in the house for the after treatment of the case, and there was a difficulty about getting nurses.

Those which occurred in my own practice happened to be the last two cases. One, a boy six years old, I saw first on Tuesday night, July 23rd, at South Head. He had then been ill four or five days. He had patches on his tonsils and some dyspnoea. But as I was told that he had been a good deal worse than he then was I decided to wait before operating. The next morning early I received a telegram asking me to go at once as the child was much worse. I found the dyspnoea very intense, so I gave chloroform and did tracheotomy at once with only an old woman seventy years of age in the room. The last case I did was a child in Waverley, aged three years. I saw the child first on July 27th. She had only been ill one day. Her temperature was 104; pulse, 140; no difficulty of breathing; well marked patches on each tonsil, these were

at once painted with pure carbolic and glycerine, equal parts. The next morning there was no fever, but the child had a croupy cough, so I knew what to expect. The next day she began to have difficulty in breathing, and in the morning of that day, forty-eight hours after first seeing her, I opened the trachea. She is now convalescent.

There is no doubt whatever, that all these cases were true diphtheria. They all had the characteristic patches on the tonsils, and in all of them thick, tough membrane was subsequently expelled or pulled out through the tracheal wound. The child that died was in the hospital. He was only two years old, and he died two days after the operation from extension of membrane into the bronchi in spite of all we could do to stop it. At the time of the operation the trachea was implicated below the opening, and although we applied the usual solvents assiduously, and afterwards used the perchloride of mercury freely, we could not check the onward progress of the membrane, which of course is necessarily fatal if it gets into the bronchi.

My thanks are due to Dr. W. Garrett for the very careful way in which he carried out the treatment of the cases in the hospital. They all needed the constant and unremitting attention which he gave them.

In the last edition of Holmes' System of Surgery, vol. ii., p. 624, it is thus written: "When the larynx is also involved in the exudation, dyspnoea and insufficient aeration of blood add very materially to the sufferings of the patient and to the probability of a fatal termination; and the question naturally presents itself whether any, and how much benefit may be anticipated from the operation of tracheotomy. It is by no means easy to give in a few words a definite answer to this question, or to lay down rules which may be sufficient to guide the practitioner in deciding on his course. If we turn to statistics we find that the fatal termination is not averted to any great extent, although in all probability some lives have been saved by the operation which must otherwise have been lost. It is indeed asserted that of late years the mortality in France after tracheotomy is not nearly so great as formerly, but this may depend not so much on the results being more favourable as on a more hopeful series of cases being selected. In such circumstances we must be guided by general principles, and the rules for our guidance must be admitted to be based partly on conjecture. It may be assumed then first of all with tolerable confidence that when the general symptoms indicate that the attack is comparatively mild, while the danger of suffocation is imminent

tracheotomy does give a chance of life in cases otherwise all but hopeless, and that it certainly does give prompt and certain relief to the suffering immediately caused by dyspnoea, than which nothing is harder to bear. But no surgeon ought to undertake the operation even in such circumstances without freely explaining that relief, and relief only from impending suffocation is its object. Secondly, when the dyspnoea is less intense it becomes a question whether the relief to the breathing may not help forward the process of cure which nature is working out; or it may rather be said whether the existing amount of dyspnoea does not materially hinder the recovery and render it more uncertain. The French surgeons are disposed to answer in the affirmative, and the opinion is shared by many among ourselves; but the practice is clearly not one that can be urged as necessary in the present state of our knowledge. Thirdly, in very severe forms of the disease we may well pause before recommending the operation, because it is no longer a question of the possible saving of life but one merely of giving temporary relief. In addition to which we must remember that the operation may entirely fail to give relief in consequence of the trachea and bronchi being blocked up by false membrane. In such cases it can only be justified by intense dyspnoea and impending suffocation, and by the earnest longing of the patient or the friends to have something done to produce relief."

Surely, gentlemen, the opinion of all surgeons who have had much to do with these cases has undergone considerable alteration since this was written. But if this is the deliberate opinion of writers in the last edition of one of the largest works on surgery in the English language, how can we be surprised that many men utterly refuse to attempt any operation in these cases? How often we hear it said, "Mrs. So-and-so's child died of diphtheria. The doctor said that there was an operation, 'cutting the child's throat,' that might save it, but that not one in a hundred recovered after it, and therefore, although he had all the instruments in his pocket, he thought it better to let the child die quietly!"

Mr. Watson Cheyne, in his paper on early tracheotomy in diphtheria in the *British Medical Journal* of March 5, 1887, says:—"Although the exact pathology of diphtheria has not yet been made out, the following is probably, roughly speaking, the state of matters. The disease is without doubt due to an organism, and from Loeffler's researches most probably a bacillus. This organism gains access to, and grows on, the mucous membrane of the throat, penetrating into the superficial layers of the mucous membrane and leading to the exudations of fibrinous

material, which together with the dead epithelial cells form the diphtheritic membrane. The bacilli grow and spread in the superficial part of mucous membrane, and as they spread the patch extends. As the result of their growth they apparently produce very toxic ptomaines, which are absorbed into the circulation and give rise to the general constitutional disturbance. Apparently, according to Loeffler's researches, the virus of the disease (the bacilli) does not penetrate into the circulation, so that the disease from first to last remains a local one, and the general symptoms are mainly due to chemical poisoning. Now if this pathology is correct it is evident that the main point in the treatment must be to prevent the local spread of the disease. If the bacilli can be destroyed or prevented from spreading the diphtheritic membrane will not spread, the formation of the poisonous ptomaines will be arrested, and consequently the constitutional symptoms will be prevented."

I think very few people will deny that the constitutional disturbance, in these cases of diphtheria bears a direct proportion to the amount of local mischief. I have often observed, and so I suppose has everybody else, that if called to a case which proves to be diphtheria, and I find that there are well marked and distinct white patches on say each tonsil, accompanied by headache, high temperature, and quick pulse, if these patches are thoroughly touched with some strong antiseptic—say equal parts of pure carbolic and glycerine—within a few hours nearly all the constitutional disturbance is at an end, and, if there is no fresh patch, the patient is well in a few days.

Now in children, for various reasons, it is very much more difficult to thoroughly paint and scrape off these patches on the tonsils, and render them aseptic. In children, also, the disease seems much more liable to spread to the larynx. Once in the glottis (in a child) I think it is impossible to thoroughly kill all bacilli. Now given a child with diphtheria, who has developed laryngeal symptoms, we know almost for a certainty that if it is to be saved its trachea will have to be opened.

We certainly always, especially in private practice, wait till it has marked dyspnoea, recession of ribs, and sternum, &c., before we operate; but we can be almost certain that these will follow directly we hear the croupy cough.

Now why do we operate? We open the trachea for two reasons; firstly to prevent, or to try to prevent the spread of the membrane down the trachea, and, secondly, to prevent the child being choked. We certainly do not, at all events I do not, operate as the writer in "Holmes' System of

Surgery" tells us, simply to give "relief from impending suffocation."

If, after opening the trachea, we find membrane there, we remove it, and do our best to render it aseptic. If we find the trachea clear, we do our best by constant observation and attention to it to keep it so.

Now as to the operation, if the child is not very young and very fat, there is nothing very formidable about it. I always give an anæsthetic. In operating I think it is best not to be in a hurry, or even get in a panic. Go calmly and deliberately to work, and put pressure forceps on anything that is bleeding much. I suppose every man has a different method of operating. Some men I know, and good men too, only cut through the skin, and then do the rest of the work with a raspatories or two directors. Now I think a great deal of damage is often done to the soft parts in this way. We must remember that we have at least two layers of the deep cervical fascia to get through, and this fascia is very tough and does not tear readily. I believe in using the knife right down to the trachea. I disregard the isthmus of the thyroid, but I nearly always go below because I always try to open the trachea as low down as possible. In opening the trachea I cut from above, downwards, and always make a free opening. When the trachea is once opened, if possible two blunt hooks should be introduced and held apart, in order that a thorough inspection may be made; in this way we see if the trachea is clear. But this is not always possible, for a variety of reasons, as anybody knows who has done many tracheotomies. If it can be done a bent probe with some absorbent wool twisted on it, after having being dipped in some 1 in 500 perchloride of mercury solution, should be introduced upwards towards the larynx, and this should not only be done once but several times. If there is membrane to be seen in the trachea, an endeavour should be made to strip it off, and then the solution of perchloride of mercury should be thoroughly applied.

This can be done sometimes better with a little pledget of wool held in a Lister's fine forceps. After this has been done, some powdered iodoform should be put on the wound, and the tube introduced.

During the operation all the swabs or sponges should be saturated with some weak perchloride solution. The tubes I use are the ordinary bivalve ones, and although they are not made with the exact curve that Parker's have, they have this advantage about them, and it is not a little one, they enable you to get at the trachea with a feather, not only at the level of your opening but above towards the larynx. This is a matter of great importance, when membrane is in the

trachea, for it enables the nurse to use a solution of trypsin or lactic acid whenever she takes out the inner tube, should occasion require it.

Now as to the after treatment: Everything to my mind depends on the after treatment.

At the end of eight or at most twelve hours after the operation the child should be taken from its cot and placed on a convenient table (a small chest of drawers answers very well) then both tubes should be removed and the trachea thoroughly inspected, it facilitates matters very much if the child is put partially under chloroform the first few times this is done. You can then see if there is membrane in the trachea. If there is it must be removed. If it can't be scraped off it must be dissolved with solution of trypsin 15 grains, with 20 grains of sodæ bicarb. and 2 oz. of water. (This solution does not keep well and it is better, as the trypsin is expensive, to get it made up in small quantities.) After the trachea has been cleared it should be touched with a solution of perchloride of mercury, 1 in 500.

For the first few times that you take the tubes out it is as well to be provided with a second set, because occasionally the two sides of the tracheal wound come together and with the child's violent efforts at inspiration, curve inwards. Urgent dyspnoea is at once produced and the child of course kicks and fights like a young fiend unless it is under chloroform. If you are not quick with the tube a catastrophe may ensue. Indeed a death has occurred in Sydney from this cause because the doctor lost his head.

If you find membrane in the trachea, and especially if it is at the level of your opening and a little below it you must take the tubes out at least every eight hours and do your best to prevent it spreading downwards. Membrane is nearly always formed in the part of the trachea that lies between the opening and the larynx, if not at first at all events within a few days. In the cases I have had lately large pieces of tough membrane have been pulled through the tracheal wound from above; once I got almost a complete cast of the under surface of the vocal cords. As long as we can maintain a healthy zone of trachea we may be easy in our minds.

But when once the membrane gets down below the tracheal opening, although we may be able to keep it in check, still we are not so certain of being able to do so. In every case I have the trachea looked at every twelve hours till I am certain that there is no chance of any fresh membrane forming.

In seeing to these cases it is best to wear a white linen coat, and if possible to protect the face in some way, for these children always cough out mucus in all directions. A laryngeal mirror on

the forehead greatly facilitates matters at night.

In one of the cases that was in the hospital, on the fourth morning after the operation the membrane began to get down below the tracheal opening and the child began to breathe quickly and with difficulty. Trypsin was applied freely, with the result that in a short time considerable relief was obtained.

On the afternoon of the fifth day when I saw the child I found her blue, dyspnoea intense, quite as bad as before the operation. I had her placed on the table, took out the tubes, and applied trypsin freely as far down as the trachea as I could reach with a feather. After a while I was able to pull up pieces of membrane with a pair of curved forceps. Perchloride solution was then applied. All the symptoms of dyspnoea ceased at once. In this case the nurse was instructed to take out the inner tube every two hours and apply trypsin, downwards through the outer tube with a feather. This child got well.

It is almost useless to do a tracheotomy for diphtheria unless you can get two good nurses to watch the case afterwards, so much depends on the nurse, especially for the first few days.

In the last case I did, while the nurse was cleaning the inner tube after taking it out, four hours after the operation, the child seized the outer tube and tore it out, and then began to kick and fight for breath. Luckily, the nurse—who happened to be a very smart one—was able to replace it. No easy matter so soon after the operation. The nurses are instructed to keep all the feathers in a solution of perchloride of mercury (1 in 2000). They do not use the trypsin unless the membrane is at or below the opening. After the operation the children are put in a tent-bed and we use steam with some eucalyptus oil in it. In this climate we may often dispense with the steam in the day time if the secretion is free. I think too much steam irritates these cases sometimes. The temperature of the cot is kept about 70 F.

I leave the tubes out altogether as soon as I am certain that the membrane has ceased forming and the child can breathe with the opening stopped up. I think the average time for the tubes to remain in is about twelve days. It is very important after tracheotomy to still watch the progress of the disease in the throat, and to keep touching any fresh patches that may form.

Gerster in his "Aseptic Surgery," gives minute directions for the performance of tracheotomy and the dressing of the wound; but he does not remove his outer tube or change the dressing till the fourth day, and, therefore, makes no attempt to prevent the membrane spreading down the trachea. He had twenty-two cases for

croupous laryngitis, and of these seventeen died and five recovered—a little over 77 per cent. is a high rate of mortality.

Looking back from our present point of view at cases we have had in the past, one cannot help feeling that many of the lives that were lost might have been saved had we adopted a more reasonable plan of after-treatment.

Formerly, the surgeon used to consider his work was at an end when he had put the tube in. The tube was put in and left there till the child died. If the membrane did not go down the trachea all the better, and, probably the child recovered, but if the membrane got down, the surgeon made little or no attempt to get it up or prevent its spreading, but shrugged his shoulders and walked off.

EXCISION OF THE RECTUM.

READ BEFORE THE MEDICAL SECTION OF THE ROYAL SOCIETY OF NEW SOUTH WALES.

By W. H. GOODE, M.A., M.D., ET CH. M. DUBL.,
HON. SURGEON TO THE SYDNEY HOSPITAL.

I BRING before you this evening a man, a portion of whose rectum I excised more than nine months ago. The particulars of the case are as follow:—

J. G., aged 59, a strong muscular man, was admitted, under my care, into the Prince Alfred Hospital on January 4, 1887. On admission he said that for 18 months previously he had suffered from attacks of diarrhoea, and that when he had not diarrhoea he was troubled with constipation. When the bowels were constipated he had a good deal of uneasiness in the region of the epigastrium, especially after meals. His health until lately had been good.

On examination he was found to be suffering from epithelioma of the rectum. The margin of the anus on the right side was the seat of a new growth, at the junction of the skin with the mucous membrane, of about the size of a florin, and, on introducing the finger into the rectum, nodules of the growth could be felt along the anterior wall as high up as the edge of the prostate. He never experienced any pain about the anal region, and referred all his trouble to the alternate attacks of diarrhoea and constipation. The rectum did not seem to be in any way constricted. His urine was acid, contained no albumen, and its sp. gr. was 1.022. His appetite was good.

At a consultation of the hospital staff it was agreed that the case was a suitable one for the performance of excision of the diseased portion of the bowel, and on January 12, 1887, the operation was done in the hospital theatre. The mode of procedure was as follows:—

The man was anæsthetised and a full sized silver catheter was introduced into the bladder and the urine drawn off, and, as was supposed at the time, eight ounces of a solution of boro-glyceride were injected; the catheter was carefully plugged and an elastic ligature placed around the penis to prevent the escape of the fluid from the bladder. The patient was then secured in the lithotomy position; the left index finger was passed into the rectum and placed against the tip of the os coccygis; a curved, sharp-pointed, bistoury was passed along the concavity of the finger and brought through bowel and skin in the median line just below the coccyx; the right forefinger was then placed on the point of the knife and the skin, rectum and intervening tissues were divided by drawing down the bistoury with a sawing motion; a strong ligature was passed through each of the flaps near the anal orifice and they were drawn back. A circular incision was next made around the anus including the diseased part. The left index finger was placed in the bowel and the levator ani muscles carefully divided. When this had been done the rectum was easily separated by the right index finger from the surrounding tissues for a distance of an inch above the disease. Chassaignac's ecraseur was then placed around the bowel and the affected part cut off. No hæmorrhage followed the use of the ecraseur. The only bleeding that occurred during the operation came from some small vessels in the levatores ani, when they were divided, and it was easily stopped; only two or three small muscular branches required to be tied. When the portion of the rectum had been removed the membranous portion of the urethra, containing the catheter, and the anterior half of the prostate gland were seen, perfectly bare, at the lower part of the wound. Two stout silk ligatures were introduced into the anterior portion of the rectum, and it was pulled down sufficiently far to cover the prostate and the ligatures were made fast to the skin of the perinæum.

The incision in the skin joining the coccyx with the anus was united by wire sutures. The wound then presented the appearance of a deep cavity, two inches across, at the bottom of which could be seen the divided portion of the rectum. The plug was removed from the catheter; but no fluid escaped; being under the impression that eight ounces of fluid had been injected into the bladder before the operation was commenced, I was rendered very unhappy by the non-appearance of the boro-glyceride on removing the plug. I could only suppose that during the operation the point of the silver catheter had in some way been forced though the bladder, and that the fluid had escaped into the peritoneal cavity. This, supposing it had happened, was a nice state of affairs.

It, however, transpired on inquiry that the gentleman to whom I had intrusted the injection of the boro-glyceride solution had not filled the gum elastic bottle, and had injected air only into the bladder. I felt considerably relieved when some twelve hours after the operation the patient passed a large quantity of healthy looking urine.

An absorbent pad was placed over the wound and the patient removed to bed. He slept well that night and expressed himself as feeling well and having very little pain about the wound on the following morning. His temperature on the night of the day after the operation rose to 102° F., and his pulse was 88, he had no pain, his tongue was moist and he slept well. On the second day his temperature was 101°, at night he slept well, and took his food with an appetite. On the third day the silver sutures were removed, his temperature was 101.4°, his pulse 84, and he complained of some pain in the wound. His bowels were kept from acting by the administration of Pil. Sap. Co. for seven days and the wound, which suppurated freely, was irrigated daily with a weak solution of Pot. Permang. At the end of a fortnight, as the wound began to close, he was made to wear a short bougie or plug, which was passed into the bowel. He made an uninterrupted recovery, and was discharged, feeling well, on the 64th day.

He presented himself again at the hospital six weeks afterwards, and said that the place was getting so small that it gave him great pain to pass the bougie which he was told to introduce every fourth day. At his request the opening was enlarged by an incision in the median line backwards, and a No. 8 rectal bougie was passed daily. He was discharged in a fortnight and given instructions to continue the use of the bougie. He has done so ever since and follows his usual occupation. There is no sign of any return of the disease. He says he must relieve the bowels the moment he feels the inclination to do so. There is a white annular band at the junction of the skin and mucous membrane. The anal opening is half an inch in diameter and allows the lining membrane of the rectum to be seen through it.

Excision of a part of the rectum was, as Velpeau states, practised in 1739 by Faget, who removed an inch and a-half of the circumference of the rectum, "and cured his patient." Lisfrance, in 1826, removed part of the rectum in nine cases, five of which recovered. The operation does not seem to have been performed again for 28 years, when Chassaignac in 1854 removed part of the bowel with his ecraseur. Since then it has been performed by Nussbaum, Volkmann, Jordan, Allingham, Holmes, Billroth, and other surgeons. Billroth says, when at Zurich, he extirpated the

rectum twelve times, of these cases six recovered and six died of peritonitis. When at Vienna he removed the lower end of the rectum in 33 cases, of these 13 died of the operation, and 20 survived the operation, but most of them died within two years from recurrence of the disease. He speaks of the severe hæmorrhage which attends the operation, and says "none of the patients died from the loss of blood, though on more than one occasion it gave cause for anxiety. He seems to have used the galvano-caustic loop in all his cases which, he says, did not lessen the hæmorrhage. The cases fatal after the operation invariably died from retroperitoneal suppuration with acute septic symptoms, and they generally died in from four to eight days. Two patients only lived longer. His conclusion is that cases, where the whole of the sphincter ani with a portion of the skin are removed, do better than those where as much as possible of the parts are left; sutures are not to be inserted as they prevent the escape of the secretions. Mr. Henry Smith records a case in which he removed a portion of the rectum, and he says "the patient lost a very large quantity of blood and remained for sometime in a state of collapse."

He called to see me about a month after this paper was read complaining of swelling of the abdomen and said he felt very ill. I found his liver enormously enlarged, being covered with large nodular masses. There was no local return of the disease. He returned home and I never saw him again; but I learned that he died about one year after the operation.

CYSTITIS IN THE FEMALE.

READ BEFORE THE MEDICAL SECTION OF THE
ROYAL SOCIETY OF NEW SOUTH WALES.

BY RALPH WORRELL, M.D., M.Ch., Hon.
ASSISTANT SURGEON TO THE DEPARTMENT
FOR WOMEN AT THE SYDNEY HOSPITAL.

I am sure you will be glad to hear that it is not my intention to occupy your time to-night with an exhaustive account of cystitis, which anyone who may be interested in the subject can read for himself in the lengthy treatises of Winckel or Skene. It will, probably, be more in accord with your wishes if I touch upon some points which have come under my own observation, and which may provoke a useful discussion.

Cystitis may be defined as a nutritive disturbance of the bladder, characterized by redness and swelling of the mucous membrane, desquamation of epithelium and increase of mucous secretion. The other coats of the bladder wall may become involved, and ulcerative processes may develop, indicating their presence by blood and pus in the urine, or the morbid condition may be carried a step further, and gangrene may result.

I need only to mention the specific cause of cystitis—croupous and diphtheritic.

In my experience cystitis is a very common affection, and I am sure all will agree with me that, in the chronic form, no disease is more intractable or gives rise to greater suffering. Any procedure or instrument, therefore, which tends to limit its frequency or favour its cure must be well worthy of our attention.

I venture to hope that the catheter, which I have the honour to submit for your inspection to-night, may be considered as in some degree effecting these purposes.

The symptoms of cystitis are familiar to us all. Frequent and painful micturition, with tenesmus, or straining after the bladder has been emptied, and alteration in the character of the urine, which contains mucous, pus, or blood, flakes and shreds of membrane according to the stage of the disease. The urethra may become plugged with these last-named, so that complete retention may occur. If unchecked, chronic cystitis ends in death from exhaustion, or uræmia, the last arising from the thickened bladder walls obstructing the orifices of the ureters, causing dilatation of these latter, and extension of the disease along them to the kidneys.

Diagnosis.—Irritable bladder in a woman may depend upon such a variety of conditions that only a systematic examination in all cases can save us from frequent error. Palpation and percussion of the lower abdomen will tell us whether the bladder be full or empty, and whether undue tenderness is present. The urethra is then examined for caruncle, and the finger tracing its course to the bladder can detect sacculation, hardness, tenderness, or irregularity from polypus. Careful palpation of the posterior bladder wall will at once disclose any hardness or tenderness—the invariable accompaniment of cystitis, bimanually a stone may be detected. Before being withdrawn the finger ascertains the condition of the other pelvic organs, in order that mechanical causes of the irritability, such as displacement of the uterus, ovaries, &c., and inflammatory conditions outside the bladder may be excluded. Piles and fissured anus are then looked for, and finally the urine is carefully examined, and the presence or absence of cystitis definitely settled.

I may here state my conviction that the examination of a woman's urine, which has been passed into a chamber utensil and brought to the surgeon in a bottle is of comparatively little value. Leucorrhœal discharge is so common, and, if present, so likely to contaminate the specimen, that I always make a point of drawing off the urine with my glass catheter at the end of the ordinary examination, when it is deemed necessary to make a urinary analysis.

Causation.—The causes of cystitis, which I have found most frequent in my own practice, are over-distention of the bladder from want of opportunity to pass water, (increased facilities for relieving the bladder and bowels are urgently needed in Sydney for both sexes) or from retroversion of the gravid uterus or from neglect on the part of the nurse or doctor to draw off the water in those rather numerous cases where ischuria occurs immediately after delivery. Other causes are injury during delivery and extension of disease from neighbouring organs, such as inflammation, abscess, cancer. Last, but not least, comes improper catheterization. How important this is, as a cause, has been well shown in the experiments on dogs by P. Dubett, which proved that decomposing urine injected into the bladder had very little effect, unless there was injury to the mucous membrane—such as the epithelial abrasion caused by frequent use of the catheter. A catheter, then, which is least likely to cause redness and irritation of the urethra and vesical neck is the one to be desired. The ordinary silver female catheter is, in my opinion the worst, and can scarcely fail to do injury. The male gum elastic catheter, generally used, has several grave defects. The eye is at the side, and, therefore, is more likely to abrade the urethra, besides a pocket is thus left at the terminal end of the catheter, which is extremely difficult to thoroughly cleanse, and finally the material is one not easily kept aseptic.

The glass catheter, which I show you, meets all these objections. It is perfectly smooth, easily cleansed, and the eye is buried in the extreme end. So that, with ordinary care, injury and septic infection are almost impossible. It consists of a glass tube, about the size of a No. 8 male catheter, one end of which is melted in the blow flame until the opening is buried, as mentioned above. One inch of the other end is bent almost at right angles with the shaft, so that the urine may drop from the extreme end into the vessel and not run back along the tube onto the vulva. In washing out the bladder, a piece of rubber tubing is slipped over the end and the nozzle of the syringe inserted into this.

Before I invented this catheter cystitis almost invariably resulted in all cases, where catheterization was necessary, for more than a few days, notwithstanding that every care was taken to syringe out the gum elastic catheter after use. Now it is quite the exception to have any trouble whatever. Of course, however perfect an instrument may be, if it is used in an improper manner trouble must ensue. The catheter should be warmed, the meatus cleansed from discharge, which might, otherwise, be pushed into the blad-

der, and the catheter introduced no further than is necessary to draw off the water, so that the walls of the viscus may not flap down on it and thus receive injury. Another important point is that in cases of great distention the bladder should on no account be completely emptied. The sudden relief of tension causing great congestion and predisposing in a high degree to the development of cystitis. A pint or a pint-and-a-half is quite as much as can safely be drawn off at once.

Treatment.—The preventive treatment has been sufficiently touched upon under the head of causation. The curative treatment consists of warm baths, rest in bed, bland diet, purgation, and hot fomentations. As medicine, in the acute stage, I prescribe the liq. potassae and hyoscyami and buchu mixture recommended by Sir H. Thompson, but in the chronic form, with alkaline urine, I generally use benzoate of ammonia, or potass chlorat.

The local treatment is of the first importance. The bladder should be daily washed out with salt and water 3i to the pint, and later on tannin 8 or 4 grains to the oz. may be substituted. If speedy improvement does not take place I practice, in addition, continuous drainage by means of a Skene Goodman catheter. The relief which follows this plan of treatment is most marked, but it can only be adopted when the urethra is healthy. If a urethritis be present this must first be cured before a catheter can be tolerated. For treating urethritis Skene's reflux catheter, which I show, will be found useful. Another mode of practising continuous drainage is by rapid dilatation of the urethra, causing temporary paralysis of the sphincter and complete incontinence of urine. This gives perfect rest to the bladder, and has the advantage that applications can be made directly to mucosa of bladder and urethra by means of a brush. Attaching to it, however is the danger of the incontinence being permanent by the occurrence of a transverse laceration of the urethra at the subpubic ligament, and a partial tearing away of the bladder from the pubes. This accident has happened to the most skilful operators, and being irremediable should make us very chary of resorting to the procedure. I have once practised it, and had a most successful result, but one case should count for little in forming a judgment upon any operation. As a final resort, in an intractable case, I should not hesitate to perform Dr. Emmett's operation of cystotomy, by which an opening is made into the posterior wall of the bladder, thus giving the diseased organ perfect rest, and allowing of satisfactory irrigation. If done before the kidneys have become involved, the results from the operation have, so far, been most promising.

DESTRUCTIVE INFLAMMATION OF TESTES—CASTRATION.

(UNDER THE CARE OF B. POULTON, M.D.,
HON. SURGEON.)NOTES BY T. A. HYNES, M.B. JUN., HOUSE
SURGEON, ADELAIDE HOSPITAL.

H.S., labourer, æt. 48, married, admitted into hospital on July 10, 1889. Patient states that a fortnight ago his left testicle commenced to swell. About five weeks ago got wet through, after which he had pain in his testicle which continued to increase till last Monday when it ceased. Since then has had pain at times. About four years ago had swelling with pain of both testicles, and last Christmas had another attack in the left testicle, this lasted seven or eight days and then the swelling disappeared. Both these attacks came on after getting wet through and being exposed to cold. Had gonorrhœa thirty years ago; also had some difficulty in passing water, with continuous pain in bladder; was treated by Dr. Markham of Port Augusta, who told him he had inflammation of the bladder; also had this bladder trouble four years ago, at same time as swelling of testicles.

On examination the left testicle is considerably enlarged, being five or six times the normal size; tender in pressure and fluctuating; the cord is enlarged and tender in the inguinal canal; cannot make out any translucency.

July 13.—Nothing found on examination of rectum; swelling of testicle decreasing.

July 15.—A hypodermic needle was put in and a quantity of thick discharge came away; under microscope this was found to be blood; heart and lungs normal.

July 17.—*Urine* acid, no albumen, no sugar, little mucus; patient etherized and Dr. Poulton cut down in front of scrotum; coverings were found to be adherent to each other and thickened; the whole of the testicle was found in a sloughing condition and was removed with the thickened coverings; drainage tubes put in and skin sewn up with silk; dressed with iodoform and gauze.

July 19.—Wound dressed; stitches causing no tension.

July 20.—Dressed; stitches cut but not taken out.

July 24.—Took away all the stitches and left tubes out.

August 8.—On examination wound healed; stump of cord still thick.

August 16.—No external wound; there is still some thickening of cord but no tenderness; no pain whatever in right testicle. *Discharged.*

Readmitted August 30, 1889.—Complains of swelling in region of right testicle; three days ago felt pain in region of right testicle, and on examination found that there was a slight swelling: saw a medical man at once who treated him, but swelling increasing he came to Adelaide hospital.

Urine.—Acid, turbid; deposit of mucus; little albumen.

August 31.—Swelling of testicle aspirated with hypodermic twice; nothing drawn away; epididymis acutely tender.

September 4.—Aspirated again with hypodermic needle but nothing drawn.

September 5.—Was ordered by Dr. Poulton to aspirate again, but whole organ became tender. Temp. rose from 98.4° to 102.4° at morn. Hot fomentations.

Evening.—Feels easier; temp. 101.6. Fomentations continued.

September 6.—No distinct fluctuation. Inserted fine trocar at spot which felt most like fluid and some blood withdrawn. Painted with Cocaine; Glycerine.

Evening.—Temp. 101.4; pulse 118, strong and full. *R* Vin. Antimoniali $\mathfrak{m}\mathfrak{xv}$ Aqua ad $\mathfrak{z}\mathfrak{i}$, three doses every four hours.

September 7.—Temp. 100.2; had an enema. Painted with Argent. nit: (20 grs. to $\mathfrak{z}\mathfrak{i}$).

Evening.—Temp. 102; sleepless; gave hypodermic.

September 8.—Temp. (morn.) 102; feeling somewhat easier; there is distinct fluctuation; can outline the testicle; swelling not so great. *R* Liq. Opii. Sed., Aq. Chlor. ad. $\mathfrak{z}\mathfrak{i}$, mane et nocte.

Evening.—Temp. 102.2; Pain less. Bowels not opened since enema, although $\mathfrak{z}\mathfrak{i}\mathfrak{i}$ of Hst. Cascara given. *R* Calomel gr. v followed in four hours by Hst. Alb. $\mathfrak{z}\mathfrak{i}$.

September 10.—Temp. 101. *R* Hst. Quininae nocte et mane.

September 12.—*R* Hst. Pot. Iodid. : t.d.s.

September 16.—Temp. normal; last night 97.6.

September 22.—Complains of pain about the testicle; temp. 100.4. Hot fomentations.

September 25.—Some purulent fluid by hypodermic needle.

September 26.—Patient etherized. Took ether very badly, at first getting almost black in the face, and only recovered when a gag was inserted. A vertical incision was made in front of scrotum, and another incision crossing this one at right angles, and a quantity of fluffy tissue was snipped off with a pair of scissors. As there was a small sinus extending downwards from here right into the body of the testicle a cut was made straight

downwards on to the testicle, and a quantity of purulent discharge came away. The testicle was greatly diseased and easily removed, the epididymis being left behind. Drainage tube inserted and the wound sewn up.

September 27.—Slept well last night; temp. 99. Dressed wound this morning, but not irrigated.

October 2.—Drainage tube left out and some of the stitches have come away. (Kangaroo sutures.)

October 3.—Very little discharge; wound healing fast; no pain.

October 10.—Wound nearly healed; no discharge.

October 12.—Wound healed. Discharged.

Note by Dr. Poulton.—This case is put on record on account of its rarity. I have not before met with such an instance of rapid destructive inflammatory action in both testicles. The organs were found to be mere disintegrated sloughs. Notable was the absence of sympathetic glandular enlargement: on the second admission all enlargement of the left cord had subsided. The general health of the patient on final discharge was excellent. The epididymis and cord of the right side were left, as there was no indication of tubercle.

CASE OF GOITRE TREATED BY ELECTRICITY.

READ BEFORE THE NEW SOUTH WALES BRANCH
B.M.A.

By V. MARANO, M.D.

THE history of this case is a brief one. Miss D—, 23 years old, a well-nourished and otherwise thoroughly healthy young lady, noticed about three years ago a pain in swallowing, at first slightly and intermittently till nine months before consulting me, when the pain became more severe and regular, noticing at the same time an enlargement of her neck and at times a sensation as of strangling. Soon after she consulted a physician, who told her she was suffering from goitre, and under whose treatment she remained for several months. On the 22nd of January last she consulted me, and on examination I found a goitre of considerable size extending to the anterior border of either sterno-mastoides. The right lobe, however, of the thyroid was the larger of the two. From the middle of the isthmus there was a pyramidal enlargement growing upwards in front of the larynx. This was

the softest part of the tumour, while the lobes were moderately hard; there was no exophthalmos, but dysphagia chiefly caused by spasm of the pharynx and the upper segment of the oesophagus.

The measurements of the neck over the goitre, which was of the fibro-cystic variety, were: at lowest part of tumour 33 centimetres and 7 mm., and in the centre of same 33.2 cm. The ordinary treatment with preparations of iodine internally and externally having been carried out for many months without the slightest benefit, I decided to treat the case by electricity, viz., strong external faradic currents suddenly interrupted and electrolysis in alternate sances. The current for the latter was given by five to eight large Leclanche cells, and was applied by placing the positive pole—a sponge electrode—between the patient's hands and by inserting in the tumour a small insulated glover's needle with which was connected the negative pole. Only on two occasions both poles were applied with needles to the tumour. One or two electrolytic and one to three faradic sances were given per week, the former of four to six, and the latter of ten to fifteen minutes duration.

On the 6th of February, when the needle had been used only twice and four faradizations had been given, the neck measured at basis of tumour 32.7; at centre, 31.5. On February 13, at basis, 31.8; centre, 31.2. February 28, basis, 31.8; centre, 31. March 19, at basis, 31.2; centre 30.8 cm. The dysphagia had almost disappeared and was noticed only occasionally on swallowing hard food. The thyroid body did not give the slightest trouble at this time, the sense of suffocation having entirely disappeared and the neck having resumed its natural size and appearance. The spasm of the oesophagus however still remained, and I had to use galvanization with a pharyngeal sponge electrode, under which method it eventually yielded, and the patient was able to return to the country in April. Between February 28 and March 19 she had seven sances with the needles and eight with faradic currents. From that date to the time she left 15 more sances were given, three of which with the needle, the others chiefly of simple galvanization with a pole to the pharynx.

A marked improvement, especially in the subjective symptoms, took place from the first seance, while, after six sances the goitre had diminished from one to two centimetres. The shrivelling, however, was not so rapid after the first three or four weeks' treatment. The method is simple and strikingly efficacious. The only pain felt is that incidental to the insertion of the needles, but I found no necessity to use the ether spray to avoid it.

ON THE IRRATIONALITY OF THE TREATMENT OF DIPHTHERIA BY STEAM.

By F. W. ELSNER, F.R.C.S.I., MELBOURNE.

THE recent outbreaks of typhoid and diphtheria in Melbourne, the former annual, the latter, *horribile dictu*, perennial and increasing in virulence every day, have no doubt furnished practitioners with much that was interesting and worthy of note, which we shall presently get the value of, let us hope. For my part, the past four years have been most instructive in the case of diphtheria, which we are now about to consider, and I think the profession generally, will agree with the conclusions derived from a fairly representative number of cases, which have been under my treatment during that period. Not long ago a New Zealand practitioner created a great sensation in Melbourne by the statement that he had treated over 300 cases at Taranaki, and that the mortality was only 9 per cent., which result he attributed to the use of the blue gum leaf vapour, derived by infusing fresh leaves every hour or so. This treatment has not been a whit more successful than any other in the hands of these Victorian practitioners who have given it a trial, and of course it could not be expected otherwise by those who know what diphtheria is, and have studied bacteriology. A paper was read on this treatment at a meeting of a medical society in Melbourne, but the discussion elicited nothing further than a general dubiousness as to the accuracy of diagnosis, not one speaker alluding to the important point as to whether or not steam is a proper agent for treating a specific disease such as diphtheria. A distinguished New Zealand surgeon, Dr. J. Carnegie Macmullen, now resident in Melbourne, indignantly refuted the statement that 400 cases per month ever occurred at Taranaki or anywhere else, and draws the inference that none of these cases could have been diphtheria, from the absence of the ordinary sequelæ. With this conclusion I heartily agree, and can only regret that a medical man could be so easily mistaken in the diagnosis of such a terrible malady as diphtheria as to publish results, which, if correct, must stigmatize the whole profession throughout the world as a parcel of fools! The originality of the treatment is *nil*, since steam impregnated with various oils and antiseptics has been used from time immemorial, and certainly *ol. eucalypti* has been one of the most frequently used in this way in Australia, so that claiming originality for using the vapour of the blue gum leaves infused, is merely hair-splitting. So much for the Taranaki sensation, which, by the way, has almost died out now.

The remarks I am about to make on the pathology of diphtheria are, of course, not original, but it is necessary to advance them again, even at the risk of seeming tedious, in order to show what definition I have accepted where so many exist. Diphtheria, then, as I understand it, is a disease characterized by the appearance upon some mucous membrane of the body of an abnormal membrane, which, even if constitutional symptoms of great severity do not immediately supervene, causes mechanical interference with the functions of the part attacked according to its situation, thus, *e.g.* the pharynx is most commonly attacked, the membrane grows downwards and involves the larynx, and the patient may be suffocated through the rima glottidis becoming blocked before relief could be given, or constitutional symptoms have had time to supervene. For the disease is at first always local; if no membrane can be seen it does not follow that it does not exist, for where there is mucous membrane there can diphtheritic membrane find a *habitat*, the back of the nares, the trachea and bronchi, the lachrymal duct, etc., being places where it can exist and escape detection until the dynamic symptoms reveal its existence. No description of the colour, etc., of this membrane is necessary, but its anatomy is the crucial point. True diphtheritic membrane is a mixture of coagulated fibrin forming a basement membrane, and various tissue constituents, upon which, and throughout which, colonies of micrococci plant themselves and multiply *ad infinitum*, unless checked; after some time they invade the circulation, develop ptomaines and the usual phenomena of septicæmia, sapræmia or pyæmia appear according to the amount of invasion. Portions of this membrane when transplanted upon the mucous membrane of certain animals will continue their growth just as if on their original soil, and the micrococci will invade the system in the usual manner (Hueter); should this result not follow, the membrane cannot be diphtheritic. It follows, then, that the micrococcus is the vehicle of infection and that it must be present to constitute true diphtheria; as is the rule in all these cases of specific origin, it is necessary to have a soil in which it can flourish, and this is, as a rule, most readily found in the pharynx, a slight catarrh, follicular pharyngitis or tonsillitis causing sufficient disturbance of the mucous membrane to allow the micrococcus to gain a foothold. Everyone runs almost the same risk of infection, medical men, of course, more than others, yet, until a lesion of some kind gives the micrococcus a foothold, he is quietly swallowed and digested, and, like the cholera bacillus which Klein ate at Bombay, causing no further disturbance. With the various degrees

and subdivisions of clinical investigators it is not necessary to interfere; the etiology is the same, the pathology differs in no way except in that of amount of membrane or of constitutional disturbance, therefore it is not difficult to elaborate what should be our treatment. The treatment should be prompt, and above all, scientific; empirical methods have almost all failed, because the pathology of the affection has been disregarded. When we proceed to make pure cultures one of the first things required is proper temperature in bacteriology; the ground for breeding having been selected and prepared, we inoculate it and place the culture in the required atmosphere, which is nearly always up to 35°C, and moist. In short then, in moist warm atmospheres colonies of micrococci flourish best, consequently, if we, by playing warm vapour upon such a festering hot-bed of micrococci as diphtheritic membrane presents, furnish the one essential necessary to promote their multiplication, is it any wonder that the results of such treatment prove negative and that the membrane grows under our very eyes? The addition of an antiseptic substance does not neutralize the evil consequences of such unscientific treatment, for were the antiseptic fluid sufficiently strong to kill the micrococci it would likewise kill the patient by absorption. Feed the patient on beef tea, chicken broth and the like in addition to this and you supply him with the very materials we use in bacteriology for pure cultivations, in which micrococci develop best and increase prodigiously. My friend, Dr. Schleicher, indeed pointed this out to me some time ago in regard to typhoid patients, and it is rarely now that one of my patients gets beef tea or other bacteriological breeding fluid as his diet. Steam and antiseptic vapour then is decidedly injurious in the treatment of diphtheria since it promotes the growth of the parasite according to bacteriological dicta which are indisputable; the diet which includes bouillon or gelatine is also unscientific and must be reformed.

Mr. Iredell, the throat specialist, in the course of conversation some time since informed me that he did not approve of the use of steam, and for the same reasons as I then advanced and am now advancing. What then is the correct treatment of diphtheria, will naturally be asked. That a single practitioner cannot possibly have the temerity to lay down. I can only say, avoid steam and use an antiseptic in glycerine, as well as an antiseptic internally, and the results I have obtained will no doubt follow in other hands too. Glycerine abstracts moisture from the membrane and prevents the antiseptic from sinking into the mucous membrane and so poisoning the individual, and the best antiseptic I have found to be

carbolic acid—our old friend. The B.P. glycerin. ac. carbol is sufficiently strong, and with it the membrane, not the whole throat, should be brushed over every two hours or less, according to circumstances. If a piece of membrane curls up at the edges it should be detached with a long forceps, regardless of the bleeding, which is easily staunches by swallowing a piece of ice. Internally, the patient gets 15 gr. of benzoate of sodium every two, three or four hours. The use of this salt is so old that I forget who first recommended it, but suffice it to say that it answers its purpose remarkably well, and is free from objection of any kind whatever. When the constitution becomes involved, as it should not be if these simple rules are adhered to, alcohol must be given with a free hand, and perhaps quinine. The patient of course keeps in bed and has a fire if the weather be very cold. *Illustrative Cases:* An old gentleman, over 70, had diphtheria some time ago. He got perfectly well under the treatment just described, but had paralysis, which has just yielded to the strychnine treatment in the hands of Mr. Iredell and myself. Three children in one family suffered from diphtheria during the recent epidemic and all got well, only one having paralysis which has since yielded to strychnine, iron and the other ordinary remedies, under the care of Dr. Cox, specialist for the throat at the Alfred Hospital, and myself. Of other twenty-one cases five only have proved fatal—one of them after tracheotomy, which was only performed in this single instance, and the remainder all recovered without secondary lesions. Twenty-five cases is not a large average certainly, but having been carefully diagnosed and noted they are of more value than hundreds of so-called cases without any corroborative evidence, in which cures are supposed to have been obtained by means which shew the diagnosis to have been incorrect, namely, the treatment by steam. I may add that during the time I have made observations upon this matter I have seen and assisted at other cases in which steam has been used, and they have all proved fatal. In these cases the treatment was not initiated by myself, they therefore do not come under the same category as those just mentioned which I have kept distinct for the purpose of analysis. These number about twelve cases, so that there is a difference between a mortality of 100 per cent. and less than 20 per cent., the latter achieved by abjuring steam, the former the direct result of adhering to its use and necessitating tracheotomy. The frequent and continuous use of steam necessitates tracheotomy by washing down into the larynx all the soluble and infectious constituents of the diphtheritic membrane, notably the micrococci, which are caught at the vocal cords and forced to

breed through being fed continuously from above. In the five fatal cases I have mentioned the larynx was only involved thrice so badly as to require tracheotomy, in only one however was it performed, in another the consultant refused to operate, and the third was negatived by the parents. In these cases the laryngeal symptoms were bad from the first, and in one of them paralysis occurred simultaneously with the other symptoms—a grave case indeed. The other two cases died suddenly from cardiac paralysis. In twenty-one cases the larynx remained either uninvolved or only to a degree not in any way dangerous to respiration and life, and therefore not suggesting surgical interference. I see no reason therefore to be dissatisfied with these results, and I think it has been shewn both theoretically and practically that steam is the very worst agent which could be used in the treatment of diphtheria.

Church Street,

Richmond (Melbourne), October, 1889.

PROCEEDINGS OF SOCIETIES.

SOUTH AUSTRALIAN BRANCH OF THE BRITISH MEDICAL ASSOCIATION.

Monthly Meeting held in Adelaide on Thursday, November 28.

Present, Dr. Cleland (President) in the chair; Drs. Morier, Corbin, Hayward, Niesche, Stewart, Symons, Davies Thomas, Hynes, A. A. Lendon, T. K. Hamilton, A. A. Hamilton, Swift, J. A. G. Hamilton, Cookson, Jay, Stirling, and the Hon. Sec., Dr. Poulton. Dr. Perks was present as a visitor.

Dr. J. Davies Thomas read the following notes on

A REMARKABLE CASE OF INJURY TO THE CERVICAL SPINAL CORD, FOLLOWED BY TOTAL PARA- PLEGIA LASTING FOR SEVERAL WEEKS—GRADUAL RECOVERY OF POWER OF MOTION AND OF SENSATION—THREATENED SEC- ONDARY DEGENERATION.

By JOHN DAVIES THOMAS, M.D., (Lon).
F.R.C.S., (Eng.) PHYSICIAN TO THE ADE-
LAIDE HOSPITAL, JOINT LECTURER ON
MEDICINE IN THE UNIVERSITY OF ADE-
LAIDE.

MR. W. L., at present aged 33, whilst hunting kangaroo in the South-eastern district of this province nine years ago, met with an extraordinary accident caused by a fall from his horse. He

remembers that he was in chase of a kangaroo which swerved to one side and was promptly followed by his horse—an experienced hunter. Mr. L. saw that a collision with a tree was inevitable, and he knows no more for a time. It appears from the observation of eye-witnesses of the occurrence that Mr. L. was carried by his horse with great force against the bough of a tree; apparently his chest received the chief impact of the shock for it was afterwards found to be bruised, whilst he had no signs of injury to his head. He was forcibly thrown to the ground, falling over his horse's hind-quarters. He was soon found to be seriously injured by his fall, the date of which I must mention was August 22, 1880, more than nine years ago. On the third day after the injury he was conveyed to Border Town, thirty miles distant from the scene of the catastrophe, and within a fortnight he made the then long journey to Adelaide where his family resides.

He came under my care on September 11, 1880. At this time his condition was apparently so hopeless that I had not the heart to make detailed notes of his case, a course I have since greatly regretted, for I am now unable to supply detailed notes of one of the most remarkable cases that has come under my observation. However, my patient has kindly consented to come here this evening and will, I am sure, with his usual courtesy, reply to any pertinent questions that may be asked. I am also indebted to him for notes of his case the accuracy of which I can fully vouch for.

I shall give his story almost in his own words: "When first I was hurt I could not speak many words at a time without a 'catching of the breath,' nor could I whistle, cough, or blow my nose, but I felt no pain provided the head and body were carefully moved in one line, but if the head were moved sideways apart from the trunk there was severe pain in the neck. I am certain that I never entirely lost all sensation; but that it was very considerably deadened in some parts and completely gone in others I have no doubt. I have a lively recollection of a pain in the left knee only a few days after the accident, and similarly in the right elbow joint. Then again I remember experimenting with my toes and legs when I would be conscious of a touch but could not localize it, and the feeling was rather an impression than the usual sensation of being touched. The power of motion had not completely gone until several days after the accident, for I recollect at Border Town (not later than the seventh day) being able to move my right arm about, but I had lost this power before reaching Adelaide. For several months I was subject to

violent jerks; the legs would jerk upwards, the knees bending. The arms, however, would be drawn stiffly down by the sides of the body. I was always conscious of the approach of these jerks, and even before they were apparent to bystanders. *Catheterism* was needed regularly for about four months; then for some time it was necessary only to start the flow with the catheter and the bladder would drain without it. I am sure that power of motion returned before complete sensation, but can give no dates. I think it was about six weeks after the accident that I was able to move my great toe on the left foot, after that the fingers on the left hand, then the left leg after a short interval of time. It was between the end of December and the middle of February that I was first able slightly to move my head from the pillow. Movement returned rapidly after a start was made. Toes and fingers recovering before legs and arms. It was about ten months before I could stand alone; soon afterwards I was able to shuffle slowly across the room, and I had to learn to walk again like a baby."

At present the patient is able to walk a couple of miles at a stretch; he can with some difficulty and with the aid of various ingenious contrivances dress himself, and he can write a good hand (sample shown), but he has to grasp the pen in his palm, and to rest his wrist on the table to write. His general health is good; he has complete control of his vesical and rectal functions, but is rather troubled with a tendency to constipation. He has for the past year or so been annoyed by well-marked fibrillary twitchings of the muscles, especially in the muscles supplied by the brachial plexus. These are aggravated by exposure to cold as when undressing. There are no twitchings in the lower limbs. Whilst enjoying a considerable amount of muscular power in the legs and arms, yet his gait is somewhat peculiar and the range of movement of the arms is limited, especially the movements dependent upon the biceps and triceps. He is unable to raise his right arm beyond a right angle from his chest in abduction, and this power in the case of the left arm is limited to about half the right angle. This appears to be partly due to atrophy of the active muscles concerned, partly however to shortening of the pectoralis major and latissimus dorsi. There is considerable limitation of the power of rotation of the cervical spine, and this is more pronounced when he attempts to look over his left shoulder. Rotation of the neck is accompanied by a subjective sensation of grating at the back of the neck. It is evident, I think, that there has been fracture of the arch of at least one cervical vertebra with subsequent ankylosis.

The Trophic State of the muscles is interesting. This presents a marked contrast on the two sides, for upon an average the left thigh measures about an inch more than the right one at corresponding places. The same remark applies to the calves of the legs.

When, however, we take the case of the *upper limbs* the conditions are different, for the right upper arm is decidedly better than the left one at the upper and middle thirds even by an inch of circumference. The right scapula is markedly "alate" in consequence apparently of atrophy of the serratus magnus.

This would point to injury of the nerve of Bell, which arises by two roots, one from the fifth and the other from the sixth cervical nerve.

Now the phrenic nerve escaped in our patient, otherwise he would not be here to-night. This arises from the fourth cervical nerve, although it also sometimes receives a filament from the fifth and sixth cervical nerves. I shall revert to the question of the localization later on. Tested by the *dynamometer* the grip of the left hand is registered as 42, that of the right one only as nine. Tested with the *galvanic current* with a large pad over the spine and the patient lying on his back, the recti of the thigh yielded Kathodal Closure contraction as follows, viz., the right rectus with 45 milliamperes, the left with 50 milliamperes.

Sensation.—During the last year the patient has been troubled with humming noises in the ears and vertigo on stooping. The power of hearing is not impaired. His sight is not seriously impaired and his optic discs offer no abnormal signs. Taste and smell remain unaltered. He complains sometimes of a feeling of "deadness" on the outer side of the right thigh and the same side of the abdomen.

Perception of Temperature.—Tested with hot sponges and cold iron, the application of a cold iron to the outer side of the right leg excites promptly a reflex contraction of the tibialis anticus and long extensors of the toes, which extends also to the anterior muscles of the right thigh, but common sensation is not so distinct as over the corresponding part of the left leg. On the left side the perceptive powers for heat and cold seem to be perfect, and no reflex is excited by the touch of the cold iron. With regard to the right a hot sponge and a cold iron yield a sense of difference which however does not amount to a clear sense of heat and cold as is the case with the left leg. As regards the sensation of the faradic current the same prevails as for heat and cold. In the upper limbs the perception of heat and cold is greater on the right than on the left side, the reverse of the condition prevailing in the legs.

Tested with the Æsthesiometer.—At the middle of the front of each thigh : In the case of the left thigh two points were recognized as such at a distance of 1.8 inches, whilst on the right side he was unable to feel them as separate points at the full range of the instrument, viz., four inches apart. There was but little difference found when this test was applied to the upper limbs.

Reflex Phenomena.—All the reflexes deep and superficial are exaggerated, and a distinct latent interval of time, amounting to some seconds, elapsed between the application of the cold iron and the occurrence of the muscular action. The higher intellectual and mental faculties are normal.

As regards the pathology of this case it seems to me evident that at the time of his fall fracture of one or more of the arches of cervical vertebrae occurred, otherwise I cannot explain. (1.) The forced immobility of his neck during several months after his injury, and (2.) The present limitation of movement of rotation in his neck, especially pronounced in looking to the left. (3.) The grating sensation felt in rotating the head.

The immediate effects of the accident apart from this were concussion of the spinal cord, followed by hæmorrhage and afterwards by myelitis. The part of the cord which apparently bore the brunt of the injury was about the origin of the brachial plexus, i.e., between the fourth and eighth cervical nerves. I think from the paralysis of the nerve of Bell that the fifth vertebra was probably fractured at the arch. There is no evidence of damage to the body of any vertebra. Much of the impairment of function of the brachial plexus is probably due to involvement of the nerves between their origin from the cord and their exit from the canal, or the two halves of the cervical enlargement were unequally damaged ; at any rate the right plexus is functionally in better condition than the left one. Strangely enough the condition of the legs reverses this.

Dr. Poulton showed a man he had trephined in September for Epilepsy, and a woman whose knee-joint had been excised in April.

Dr. J. A. G. Hamilton showed Renal Calculi. He had excised the kidney ; the patient made a good recovery.

The minutes of the previous meeting were read and confirmed.

An apology was read from Dr. Gardner, who was unable to attend.

A letter was read from the New Zealand Medical Association inviting the attendance of members at their annual meeting, in February, during the currency of the Dunedin Exhibition.

Dr. R. S. Rogers, of Port Wakefield, and Dr. E. A. Mackay, Adelaide, were elected members.

Dr. J. Davies Thomas then read notes of two cases of "Hydatid Disease," as follows :—

ENORMOUS ECHINOCOCCUS CYST OF LIVER, WHICH FILLED THE GREATER PART OF THE ABDOMEN AND PELVIS, SIMULATING EXTREME ASCITES; LAPAROTOMY—CURE.

By JOHN DAVIES THOMAS, M.D., LOND., F.R.C.S. ENG., PHYSICIAN TO THE ADELAIDE HOSPITAL, AND JOINT LECTURER ON MEDICINE IN THE UNIVERSITY OF ADELAIDE.

On October 16, 1888, I was summoned to consult with my friend, Dr. Dawes, of Gawler, upon the case of Mr. P. H. C. who resided in the neighbourhood of Gawler. The patient, a young man, 25 years of age, looked pinched and worn ; his lips were dry, his tongue tender and raw-looking, the eyes were sunken and the conjunctivæ showed a plain icteric tint, which, however, did not amount to distinct jaundice. Temperature 101°. He could give but little history of the illness, which seems to have crept on him almost imperceptibly. His family, however, had noticed an increasing enlargement of his abdomen for nearly a year past, and he himself noticed that he had to leave unfastened the top button of his trousers for two or three months past. On September 27—about three weeks before I first saw him, he felt a sudden sense of "deadness" in the abdomen, and towards evening the uneasiness amounted to acute pain, which was most severe about the navel ; this continued for about a week when vomiting set in and persisted for about three days. Upon examination, the abdomen was found highly distended, and presented the symmetrical character of well-marked ascites ; there was pronounced protrusion of the umbilicus ; a distinct percussion wave could be elicited on tapping the front of the belly, but there was here no resonance of intestine. The subcutaneous veins over the lower parts of the chest and both hypochondriac regions were unusually distinct. There was moderate tenderness on pressure over the abdomen. An exploratory puncture yielded a little puriform fluid, the canula being soon blocked.

The diagnosis was a very large abdominal hydatid, and a radical operation was advised and readily acceded to by the patient who was removed to the Private Hospital, North Adelaide, for this purpose, on October 16. He bore the fatigue of the journey well.

October 17.—Operation: With the assistance of Dr. Dawes an incision about three inches long was made in the median line below the umbilicus, and over the most prominent part of the bulging abdomen. When the peritoneum was reached it was noticed to be particularly tough; this was afterwards explained by the close adhesion of the fibrous capsule of the parasite. The sac was then opened freely and over two-thirds of a bucketful of puriform fluid and daughter-cysts escaped; the latter ranged in size from that of a pea or smaller, to that of an orange and they reached the number of several hundreds. Some were transparent and apparently still living, others were still entire, but flaccid and variously stained orange or greenish, others were collapsed and empty. The mother-cyst was already broken up into fragments, and these were stained deep-green. The solid and fluid contents of the sac were carefully removed by douching with boric lotion and the free use of forceps and sponges, &c. When this was done the interior of the abdomen gave my colleagues and myself the impression that the whole viscera of the abdomen and pelvis had been removed. A further examination showed that the parasite had started from the under surface of the liver, had grown down through the abdomen and filled the pelvis, whilst the stomach, the bulk of the small intestine, &c., had been pushed below the margin of the thorax into the region of the spleen; the fibrous capsule was adherent posteriorly and anteriorly to the respective walls of the abdomen, and the cæcum, colon, and rectum were thus completely concealed. During the process of convalescence, the shape of the abdomen was grotesque, for gradually the stomach and intestines descended as a marked protrusion of the upper abdomen, whilst the lower part of the abdominal wall fell back almost to the lumbar spine and then rose to the pubes.

It is unnecessary to relate in detail the history of his convalescence, except to remark that in spite of the retention of large drainage tubes reaching to the floor of the pelvis, the secretion of the sac collected in the pelvic cavity and caused slight evening pyrexia. I consequently found myself obliged to use injections of thymol to wash out the puriform secretion; this pus, however, continued aseptic. Ten days after the performance of the operation it is mentioned in my notes that "he gets up for an hour or two daily." On the fifteenth and sixteenth days there was a stain of bile in the discharge. The pelvic drainage tube was removed finally on the seventeenth day, but it was now replaced by one directed upwards and to the right—evidently the place of origin of the parasite. On the twenty-fourth day the patient left the Hospital for his home, but he

was requested to present himself occasionally for inspection to Dr. Dawes. The tube was finally removed on January 19, 1889, three months after the operation. I have seen and heard of the patient frequently since, and his health is excellent.

The following are the chief points of special interest in this case, viz., (1.) The enormous size of the hydatid. (2.) The extraordinary amount of compression and displacement of the abdominal viscera, yet the completeness of the patency of the intestine, &c. (3.) It should be added that it was clear that an influx of bile had taken place before the operation and had killed the mother-cyst and probably most of the daughter cysts. In the interior of many of the latter were small collections of bilirubin. (4.) The difficulty of drainage of collections of fluid in the pelvis, especially if the descent of the small intestine into that cavity is hindered, as in this case; such retained secretion usually becomes purulent in the course of a few days, even under strict antiseptic treatment. It is therefore important to drain freely such gravitation collections, and instead of injections it is best to use antiseptic capillary drains of lamp-wick, which can be passed through the india-rubber drainage tubes down to the bottom of the pelvis. I have recently had occasion to use them in a case of ovariectomy where the very firm pelvic adhesions present had necessitated much tearing of small vessels in the depths of the pelvis; the plan of drainage answered admirably. In another case also it was most satisfactory; this was a huge hydatid of the left lung, which was thoroughly drained by the capillary attraction of lamp-wicks passed loosely through the two large drainage tubes of india-rubber employed.

LARGE ECHINOCOCCUS CYST OF THE LEFT LUNG—SPONTANEOUS RUPTURE INTO A BRONCHUS—SUDDEN DEATH.

J. H. S., master mariner, of Port Adelaide, consulted me for the first time on November 16, 1888. Born in London, he went to sea at the age of 18 and has spent most of his life in this vocation. For some years past he has chiefly been engaged in the trade between Australia and Mauritius, but for about three years, viz., 1879-1882, he was engaged in shore employment as foreman inspecting the construction of jetties, railways, &c. During this period he lived at Waterloo, Venus, and Dutton Bays and frequently drank foul water. He has also resided for a few months at other places, notably at Custon and

Kingston in the South-Eastern district of this colony. Since 1882 he has been employed in the Mauritius trade making about four trips yearly to Port Adelaide. In July 1885 he caught cold and coughed for about six weeks; in consequence of this he consulted a medical man at Mauritius, who seems to have observed something wrong with his left lung, but the patient did not know what. Three months later he was troubled with pain in the lower part of the left chest in front, which was most marked when he was tired or mentally troubled. He further stated that the cough was rarely troublesome to him. He spat blood once, viz., about four weeks before he consulted me; it was small in quantity and merely streaky. Upon examination, the patient appeared to be a healthy-looking man of about the age he stated himself to be, viz., 38. There was impaired movement of the lower part of the left chest, particularly posteriorly; below the angle of the scapula there was absolute dullness with abolition of vocal fremitus and total respiratory silence. There was no lateral displacement of the heart, for the tumour did not extend much into the axillary region, but during expiration the pulsation of the heart was visible over too large an area; cardiac sounds normal. The diagnosis was, large hydatid cyst of inferior lobe of the left lung; the danger of rupture of the parasite was pointed out to him and a radical operation was urged on him. However, in spite of the remonstrances, both of Dr. Mitchell, of Port Adelaide, and myself, he delayed his consent and started for "one more voyage" to Mauritius. On January 28, 1889, at Port Louis, whilst laughing and jesting with some friends, he ruptured his cyst and died suffocated, having time only to exclaim "I am done for." This case well illustrates the danger to which a patient with a large unruptured pulmonary echinococcus is exposed, and is by no means unique in its termination.

A discussion followed. The president announced that there would be no meeting in December.

NEW SOUTH WALES BRANCH OF THE BRITISH MEDICAL ASSOCIATION.

THE 86th general meeting of the Branch was held in the Royal Society's Room, Sydney, on Friday, 1st November, 1889. Present: Dr. Fiaschi (President) in the chair; Drs. Hankins, Williams, Cohen, Wilkinson, Orago, Jenkins, Wm. Chisholm, Rennie, Scot-Skirving, Foreman, Quaife, Clubbe, McDonagh, Lyden, Worrall, Beith, W. J. O'Reilly and Morgan Martin.

The minutes of the previous meeting were read and confirmed.

DR. TRINDALL, of Helensburgh, was elected a member of the Branch.

The PRESIDENT (Dr. Fiaschi) read a paper on a "Case of Goitre Treated by Electrolysis" for Dr. Marano, who was unavoidably absent.

MR. G. T. HANKINS read some notes on "Wind Instruments—Their Relation to Health and Disease, with special reference to Phthisis and Emphysema of the Lungs," with demonstration and exhibits.

DR. SCOT-SKIRVING said he was under a personal obligation to Dr. Hankins for many thoughts suggested by, and arising from, the demonstration. It might interest Dr. Hankins to know that in the Hebrides there was an old wise saying to the effect that those persons who play the bagpipes are freer from consumption than others.

DR. BEITH said he did not rise with the idea of discussing the paper but to make a few remarks as to emphysema. He (Dr. Beith) was for a considerable time under Dr. Gardner, who believed in the inspiratory theory. The speaker pointed out the exact views of Dr. Gardner on this subject.

DR. O'REILLY suggested that Mr. Hankins should repeat the demonstration before the Medical Section of the Royal Society.

DR. JENKINS said he would also like Mr. Hankins to repeat his demonstration at the next meeting of the Medical Section of the Royal Society. He (Dr. Jenkins) knew that his brother had been very much benefited by playing the bagpipes. Dr. Williams could testify to this as he had examined him.

DR. FIASCHI said no doubt this paper would assist the profession to advise in the future as to the best of the wind instruments to commend to their patients. He (Dr. Fiaschi) would suggest that a comparison as to the relative advantages of other musical instruments might also be made.

MR. HANKINS, in reply, thanked the members for their expressions of opinion.

DR. CAMPBELL WILLIAMS read some notes on a case of "Inguinal Colotomy."

DR. WORRELL asked how the bowels operated between the first and second operations.

MR. G. T. HANKINS said he must congratulate Dr. Williams on the success of the operation. He (Mr. Hankins) had had a few cases of colotomy, and had always done the lumbar operation, but would do the inguinal in future. It appeared that Mr. Allingham's method of pulling down a large portion of the bowel was too severe. He (Mr. Hankins) would follow Mr. Cripps' plan of only pulling down a small portion of the bowel.

DR. WM. CHISHOLM said he noticed that Mr. Jessep at Leeds still advocated the old method, but there was no doubt the inguinal operation was very much easier.

DR. WILLIAMS, in reply, said in the statistics of the two operations the mortality was as follows:—Lumbar operation, 40 to 60 per cent.; inguinal colotomy, 5 to 7 per cent. Besides which the operation is easier and you have a better control of the case altogether. With regard to Dr. Worrall's question there was a slight watery motion between the first and second operations, but afterwards there was no motion, the patient being under opium.

The HON. SECRETARY gave notice of the following notices of motion in the name of Dr. Hodgson:—1 "That a committee be appointed to explain to newly-arrived medical men who intend practising in New South Wales, the laws and ethics regulating medical conduct in the colony." 2, "That such committee seek the assistance and co-operation of any delegates commissioned for the same object by the sister medical assembly in Sydney.

NOTICE.

The Editor will feel obliged by any gentleman, who wishes to ventilate any subject of professional or public interest, writing an editorial or leading article on it, which if found on perusal to be consonant with the policy of the paper, will be inserted in an early number.

All communications intended for the Editor should be sent to the 'A. M. Gazette' Office, 35 Castle-reagh Street, Sydney.

** * Contributors can have their Papers reprinted and published in Pamphlet form, at Cost Price, if the necessary instructions are given to the Publisher at the same time the contributions are sent in.*

AUSTRALASIAN MEDICAL GAZETTE.

SYDNEY, DECEMBER 15, 1889.

EDITORIALS.

THE AUCKLAND (N.Z.) HOSPITAL.

A CASE which recently occurred in the Auckland (N.Z.) Hospital, is of very great professional interest as showing the duties and responsibilities of the Honorary Staff of a public hospital in relation to major operations. It appears that a Mrs. Howe was an in-patient at the hospital under the care of Dr. Bond, who removed the ovaries with the view of curing uterine trouble and not on account of any disease in themselves. The patient died on the sixth day from uræmic poisoning, following suppression of urine.

When death occurred the fact came out that no regular consultation of the Honorary Medical Staff, as is required in major operations by No. 22 of the hospital rules, had taken place, but that only one or two irregular opinions on the proposed course had been given by individual members of the staff. The husband, who had been apparently moved thereto by some person or persons inimical to Dr. Bond, then denied that his consent to the operation had been asked, but in our opinion and that of the Hospital Committee this has been disproved, for if he did not express actual consent he gave tacit approval to it.

We think that the absence of the required consultation is much to be regretted, and that it is a serious mistake on the part of the Honorary Staff of any hospital to permit a colleague to habitually neglect to obey the rule requiring it, for if he is so reckless of his own safety as to do so, he has no business to risk the good name of the institution and the reputation of

the other members of the professional staff by doing so. We think in such a case that after due private protest, if it prove ineffectual, the other members of the staff, either collectively or individually, are not only justified but in duty bound to call the attention of the governing body of the hospital to the breach of its rules. It is not necessary that though a majority of the staff are of opinion that a particular operation is uncalled for, that the surgeon in charge of the case should not perform it, but he should then only do so after having placed all the opinions, both antagonistic to and in favour of his view before the patient and her or his friends, who could then elect either to abide by his opinion and submit to operation or decline it. We think the finding of the Committee not an unfair one, and are of opinion that it had no choice but to request Dr. Bond, who has rendered in the past good service to the hospital, to resign his post as honorary surgeon. The finding of the Committee is as follows:—"1. That, in the opinion of this Board, the operation upon Mrs. Howe was performed in direct violation of rule 22 of the Hospital, which provides for a consultation of the medical staff before any major operation is performed. 2. That we believe Mr. Howe did know that his wife was about to undergo a serious operation, and that he made no objection. 3. That the Honorary Medical Staff have been guilty of serious negligence in not complying with certain rules of the Hospital, and in not reporting to the Board the violation of rule 22 by one of its members. 4. That it be an instruction to the resident medical officer to report immediately to this Board any further violation of the rule by any member of the Honorary Staff. 5. That as it appears impossible that the Honorary Visiting Staff as at present constituted can work harmoniously together, Dr. Bond be asked to resign his position."

THE ORANGE (N.S.W.), HOSPITAL.

CASES, which from time to time come before the higher courts of the colony, go to show that the goodness of the management of the Hospital at Orange is open to question. The differences of opinion on this point being very marked, the one side positively asserting that everything is and has been as it should be, whilst the other makes equally trenchant statements to the contrary.

To our mind the verdicts both in the first trial and in the new one ordered by the Full Court, in the case of *Davies v. Goode*, are unsatisfactory. For we think that Dr. Goode believed he was acting in the interests of the hospital when making the complaints he did against the con-

duct of the matron, and this we take it was the view of Mr. Justice Stephen who presided at the last trial.

If there were even suspicion of abuses in the management of the hospital or the treatment of inmates, it was eminently the duty of a member of the medical staff to cause enquiry to be made, and it cannot be conducive to the public interest that any man should, in carrying out what he conceives to be his duty, even if he be open to the accusation of acting rashly and inconsiderately, be subject to such pecuniary loss as may practically amount to his temporary ruin.

We again reiterate the opinion expressed in our September number that disinterested inquiry into the past and present management of the Orange Hospital is required in the public interest, and that such an inquiry would be most fittingly made by a gentleman specially appointed by the Government as the chief supporter of the hospital, who would be unbiassed by local influences.

DR. SPRINGTHORPE AND THE SANITARY COMMISSION IN VICTORIA.

SANITARY matters have reached a stage in Victoria, at which outside professional criticism is not only appropriate but can no longer be withheld. It will be remembered that some two years ago a Royal Commission was appointed in that colony to enquire into and report upon the sanitary condition of the metropolis. The members of the Commission were: Professor Allen (Chairman), Professor Masson, Dr. McCrea, Mr. Girdlestone, Mr. Akehurst, President of the Central Board of Health, Mr. Clement Hodgkinson, and the Hon. James Campbell, ex-Postmaster General. In pursuance of their investigations the Commission visited both Sydney and Adelaide, and published two progress reports, dealing with the various sanitary questions which came under their notice. The Commission, indeed, was pursuing the even tenor of its way, and would, no doubt, have run its course without disturbing the public atmosphere to any extent, with the usual problematic utility in the distant future, had not a sudden and unexpected discovery completely altered its programme. This was the alleged discovery in June last, by M. de Bavay, a practised bacteriologist, of Eberth's typhoid germ in water taken from a Yan Yean pipe. The value of the discovery was attested by Dr. Springthorpe, lecturer in hygiene to the Melbourne University, and Secretary to the Sanitary Section of the recent Intercolonial Medical Congress. Subsequent proceedings have been both interesting

and exciting. Naturally the discovery was at first discountenanced by all and sundry, especially those whose past *dicta* were thus indirectly impugned. The Sanitary Commission speedily took steps to further investigate the question of this typhoid contamination of the Metropolitan water supply, and for that purpose engaged Dr. Katz of Sydney. From a variety of reasons—which appear to us quite justifiable—M. de Bavay and Dr. Springthorpe decided to submit to Dr. Katz a sample, not only of germs taken from the water, but also one taken some time later from a human spleen, extracted from a typhoid patient—placing sealed envelopes, at the same time, in outside hands, with full information as to which was which. In due course Dr. Katz gave his opinion that both specimens contained undoubted typhoid germs. Meantime strained feelings made themselves apparent between the different parties concerned, culminating in some strong strictures upon M. de Bavay by the President of the Commission. The unexpected result was an exposure by Dr. Springthorpe of shortcomings upon the part of the Commission itself in the discharge of its important duties. With a cleverness and a relevancy which cannot be denied, that gentleman put the Commission under a hypothetical cross-examination and he certainly seems to have exposed them to fair charges of very grave neglect, the accuracy of which the Commission has not yet attempted to disprove. From this cross-examination it would appear that the Commission, though making much of the importance of the question of water supply, let 16 months pass before reporting thereon, that when they published their report it contained no reference to the presence or absence of the typhoid germ, and that the analyses upon which it was based were insufficient to detect the bacillus. The Commission are charged with grave neglect in this matter. It was pointed out that the expert of the Commission, Dr. Katz, had nothing but negative results to show after three months' work, and admissions were obtained from him shewing that the reason might have been other than the actual absence of the germ. Dr. Katz has since set himself once more to make test investigations, and this is the stage at which matters now rest. We await therefore with considerable interest the publication of Dr. Katz's report and of the final statement of the Commission. So far success has been entirely with M. de Bavay and Dr. Springthorpe. By them the fact of the discovery of the germ in the water supply was first published, and by them also the work of the Royal Sanitary Commission in respect to water supply has been shewn to have been misleading. Meantime we take the opportunity to congratulate M. de Bavay upon his

successful isolation of the typhoid germ from water—an achievement which he has been the first man in Australia to perform.

DR. H. L. SMITH V. THE WESTERN AUSTRALIAN GOVERNMENT.

THE *Australian Advertiser*, published at Albany (Western Australia), gives a synopsis of the treatment meted out to Dr. Smith of that place, which as of general professional interest we think it well to republish:—

“Dr. Smith was appointed Acting Medical Officer at Albany in July, 1887, succeeding Dr. Rogers, whose practice he purchased. With Dr. Stewart as his assistant he carried out his duties in a satisfactory manner, but was dismissed in September of last year. The ground of the dismissal had relation to the inquest upon a hospital patient named Webb, a boy who died of fever. The patient was lying in the old hospital on July 17, when the workmen of the Land Company began to pull down the place. There was a boundary wall to the hospital grounds. The evidence at the inquest showed that Dr. Smith gave permission only to pull down the boundary wall which did not effect the main building. He visited his patients shortly after 3 o'clock on the afternoon of the 17th this being his third visit during that day, and then he noticed nothing that might be taken as a breach of his arrangement with the company. According to the evidence the removal of the door exposed the boy Webb and the other patients to a biting wind that blew all night. The orderly, an old man, hung up blankets across the doorway to protect the patients, but these were blown aside during the night. The evidence showed that the boy was doing well prior to this night and that he died next day at the new hospital to which he was removed. The evidence also showed that Dr. Smith was not informed of the taking down of the door until next day. The jury in their verdict threw the blame for what had occurred upon the orderly and also upon Dr. Smith for having allowed any interference whatever with the hospital premises. This verdict was, we think, unnecessarily severe, and in fact not a fair deduction from the evidence. Whether they had instructions to do it or not the workmen, as a matter of humanity, should not have pulled down the hospital door. The doctor also had every reasonable ground for believing that the arrangement he had made with the company would be respected. We recall these facts in order to point out how utterly unwarrantable and unjust was the doctor's dismissal. He was dismissed in September, on a charge practically amounting to manslaughter, his services to cease on December 31. He appealed to the Secretary of State in the matter, who however declined to interfere, and finally he left the service in March last, eight months after the alleged manslaughter. He commenced proceedings against the Governor for a libel and wrongful dismissal, but the firm of solicitors in Perth, who had the matter in hand for about three months, declined to go on with it. As he found it impossible to take his action personally against the Governor, he, last month, served a writ under the petition of right upon the Government. The Governor, we learn, has replied to the effect that this petition of right is an infringement of the Royal Prerogative, and has refused, we understand, to give

the doctor a hearing upon it. The Governor has referred this new phase of the matter to the Secretary of State to ascertain if he may order that the petitioner be given a hearing. Dr. Smith is pushing this matter in order to obtain a removal of the stain upon his professional character that naturally results from a dismissal, and it will be harsh treatment of a public official if he be denied an opportunity of justifying his conduct with respect to the alleged offence for which he was dismissed. There is one thing very certain and it is that if the jury had foreseen the advantage that would have been taken of their verdict to dismiss Dr. Smith, they would have taken care to modify it very considerably. As it was no reasonable person could have found in the verdict any ground for such a severe punishment to a professional man as that of dismissal from the public service.”

Our readers will see from this that service as a medical officer in a Crown colony is not a bed of roses. In our opinion the verdict of the jury was not justified by the evidence, and we think that in that spirit of fairness which is so essentially British that he should have been permitted to take such legal action as he thought necessary to obtain redress. We sincerely hope that the Secretary of State for the Colonies was not moved by his subordinate, the Governor of Western Australia, to refuse this very reasonable request of, we submit, an injured man.

THE fifth annual meeting of the New Zealand Medical Association will be held in Dunedin on Wednesday, February 19 next, and following days. The above date has been fixed in anticipation of its suiting the convenience of members of the profession in Australia who intend taking a holiday during the progress of the N.Z. Exhibition. The President and Executive Committee of the Otago Branch (Dunedin) of the Association offer a cordial invitation to all medical men to attend the sittings, though business can only be transacted by members. Papers, exhibits, &c., are invited on any medical, surgical or special subjects, and on subjects allied to the science of medicine. A programme will be printed about the 1st of February, and all those intending to contribute any material should communicate with the Hon. Sec., Dr. Gordon MacDonald, High street, Dunedin, on or before that date, so as to ensure their names and titles of papers, &c., being entered on the programme.

DOCTORS' CLAIMS FIRST.—Medical men in general probably are not aware that in France, at least, the doctor's claim on the estate of a deceased patient has precedence of all others. Even the landlord's claim for arrears of rent must yield to the doctor's fee. The courts of Rouen, Poitiers, and the Seine have alike decided that as it is an imperative right of humanity that the dying should have the necessary care and treatment, such attendance should be paid for before all other debts.

LETTERS TO THE EDITOR.

A QUESTION OF MEDICAL ETIQUETTE.

(To the Editor of the A. M. Gazette.)

SIR,—A and B are practitioners in the same town. Z is a patient of A's, and late one evening Z's wife, who had always been attended by A, is seized with labour pains and sends for A. A is not in, and the messenger is instructed by A's servant to go to B, who lives near. B attends and the confinement is got over satisfactorily. The following morning B sends A a letter to say that he has attended Mrs. Z, and asks if A will attend during the puerperium or not. A sends back a verbal message that he will call and arrange with B, but instead of doing so he takes advantage of the time thus gained and goes to see Mrs. Z. B waits till the afternoon, and having heard nothing more from A he goes to pay the necessary visit to Mrs. Z. When he arrives he finds A was there in the morning. B immediately withdraws from the case and writes to A, saying his conduct prevents him (B) acting as his deputy in future.

Later B sends Z a bill for half an ordinary midwifery fee, which A instructs Z not to pay, and sends Z an account for the full fee.

Is not Z directly liable to B for half the fee, and could not B recover in a court of law? If not, can B recover from A in a court of law?

HONESTAS.

[It is a nice point whether the servant of A was in his absence so absolutely his agent as to commit him to legal liability as the employer of B. This would, we think, depend on the evidence given in court by the servant as to the instructions given by A to him or her. Morally A is indebted to B for at least half the fee, and is contemptible and mean if he disputes or neglects to pay it. Failing A realizing his responsibility B would be justified in suing Z for a reasonable fee, which the half certainly is, and he would undoubtedly recover it in a court of law, as Z by his accepting B's services became at once responsible to him for proper remuneration.—ED. A.M.G.]

VOLKMANN'S METHOD FOR ECHINOCOCCUS OF LIVER.

(To the Editor of the A. M. Gazette.)

SIR,—Allow me a little space to say a few words in reply to letters written by Drs. Thomas, Marano and Gardner *re* Von Volkmann's method.

Dr. Thomas asserts that both Lindemann's and V. Volkmann's methods are easy of performance. I cannot say this of the former when skilled assistance is only procurable for the administration of chloroform. I must confess I feel rather anxious under such circumstances until stitches are securely fastened. I have not yet met with a mishap during that operation, but I always see in my mind's eye the lay assistant in charge of the loops swooning. A fainting lay assistant is by no means uncommon in my experience. But apart from this, if these operations are so easy why do not our best surgeons adopt them? Is it the want of reliance on asepsis? What the operation performed by Dr. Gun of Philadelphia has to do with discrediting V. Volkmann's method is beyond my conception. The essential and intrinsic part of the latter method, that which distinguishes it from the older French method, is that the *peritonum* or the *pleura*, as the case may be, are opened. That Gun

expected to find adhesions is proof positive that his ideas about asepsis and antiseptics were not very clear.

Dr. Thomas insinuates that I had mistaken the capsule for the parasite while trying to remove it. I know this has happened to even our most eminent surgeons. It is a well known fact that in some cases circumscribed or diffuse inflammatory processes take place around the cyst, as result of which abscesses are found. Now I ask why it should be so impossible for these to stop short at the formation of adhesion? In my case the cyst came away in minute particles. This at least is some proof that adhesions were present.

In answer to Dr. Marano I may say that I will never hesitate to adopt V. Volkmann's method in a case where skilled assistance is out of the question altogether and where cocaine is appreciable.

Dr. Gardner thinks that V. Volkmann's method is the best adapted for bulging cysts, but the majority of my cases were of the non-bulging form. In his last argument I join issue with Dr. Gardner. Should there be possibility of intestines getting implicated in any way, I should at once adopt Lindemann's method. But to avert this mishap as far as possible, I make the incision somewhat above the zone of absolute dulness.

Shortly I intend publishing two more successful cases of V. Volkmann's method for hydatids, the nature and locality of which will conclusively prove its safety and efficacy. One was a hydatid of very large dimension situate on convexity of liver (briefly mentioned in my paper.) The other a hydatid in left lung of almost equally large dimensions. This patient was a weak man about 60 years of age. Within three weeks of the operation he was walking about.

In conclusion allow me to express my hearty thanks to the writers for the interest taken in my paper.

I am sir,

Your obedient servant,
J. B. ROSS, M.D.

CLOSURE OF JAW DUE TO IRRITATION OF TEETH.

(To the Editor of the A.M. Gazette.)

SIR,—I do not consider this condition as uncommon, as your correspondent, Dr. Pinnock, of Ballarat, makes out. I have had two cases within the last few months, one very similar to the case reported:—

C. A. C., labouring man, set. 28, married, strong and healthy. He had been ill for two days before I saw him; feverish headache, and pain and stiffness situated in the region of the left masseter with some swelling; the jaws were firmly closed, the teeth could not be separated more than quarter-of-an-inch. Hot fomentations and internal remedies were of no avail. I passed my finger between the cheek and teeth, and found the lower left wisdom tooth still uncut, and the gum over it very swollen and tender. I did not aspire to the refinement of diagnosis as to whether there was room between the ramus of the jaw and the second molar, nor adopt the heroic treatment of removing two teeth under such trying circumstances, but I passed carefully a guarded bistoury inside the cheek and freely scarified the swollen gum, in a few hours relief was obtained, and next day the patient could eat solid food, whereas for five days he had taken nothing but a very small quantity of fluid.

The second case was due to the irritation of a decayed tooth.

A. H. GAULT, M.B. London, etc.

Mitcham, South Australia, December.

COMPOUND COMMUNUTED FRACTURE OF THE FEMUR.

(To the Editor A. M. Gazette.)

DEAR SIR,—I have to thank Dr. Monsell, of South Australia, for his suggestion. I should have explained in my notes that 40 grains of hydrate of chloral were given through the night in divided doses.

Having found the chloral ineffective, and having learnt from the patient that he had been accustomed to take large doses of laudanum, I gave the dose of liq. opii. sed. on the 9th, which Dr. Monsell justly says is a large one. I knew it was.

On the 12th, however, I gave the same dose without effect, and on the 13th, 3i was given in two doses. During this time it was not at all clear to me what was producing the pain, and I was bound to control it. As soon as the fragments of lead were removed he required no more narcotics, although he did not sleep very much even then, but the weather was hot and the mosquitoes so troublesome to deal with that I was not surprised. The ants, too, were always on the alert, and although the legs of the bedstead were protected, yet, if accidentally the mosquito net touched the ground, they swarmed up at once, and the patient got no rest till they were ejected.

The combination of pot. brom., hydrat. chlor., and liq. opii. sed. is one I have used frequently, but, I think, where I am compelled to use such large doses of it, that the plan I adopted of giving large doses of one drug was the more advisable.

With Dr. Monsell's concluding remarks I agree. It would have been better for him to have remained longer, but he wished to return. I am informed he is now riding about on horseback again, so I presume his recovery is assured. The femur was so very much shattered, and the pieces of bullet had travelled through and pulverized so much tissue that I did not expect the wound would close up for some time after he left me.

Yours faithfully,

ARTHUR SALTER, M.B.

Thursday Island, Oct. 31, 1889.

THE MONTH.

NEW SOUTH WALES.

MR. HENRY COWARD, M.R.C.S. Eng. 1841, of Twyford, near Germanton, a highly respected colonist of 48 years' standing, expired suddenly at his residence on Sunday night, November 24. The deceased gentleman was 71 years of age and was well known in both New South Wales and Melbourne pastoral circles. He had had several ups and downs in his early days of colonial life, but during the last 15 years had been very successful, and at the time of his death owned, in partnership with his two sons, in addition to the above property, the Lessington station, near Bourke, and the Carrawobity station, near Forbes. He enjoyed good health to within a couple of days of his death. He was on the point of taking his fourth voyage to England, having decided to start next month. He had been a resident of the Germanton district for 20 years.

We deeply regret to have to announce the death of Mr. Owen Spencer Evans, M.R.C.S. Eng. 1851, an old and greatly-respected practitioner at Balmain (Sydney), who lost his life through a buggy accident on November 20. The deceased gentleman was out in his buggy when the horse bolted, capsizing the vehicle and throwing him violently upon the road. He was at once

picked up but almost immediately expired, and subsequent examination revealed the fact that he had sustained a severe fracture of the base of the skull. Dr. Evans arrived in the colony 36 years ago, and for many years past practised in the Balmain district, where he was held in great respect. He was a member of the N.S. Wales Medical Board, Visiting Surgeon to the Biloela gaol and the training ship "Vernon," also Staff-surgeon of the Naval Brigade; formerly he held the position of Surgeon to the late penal establishment of Cockatoo Island, Port Jackson. The deceased gentleman was 59 years of age.

MR. THOMAS BUSICK HAYLOCK, M.R.C.S. Eng. 1827, L.S.A. Lond. 1826, died at his residence, Orpington-street, Ashfield, near Sydney, on November 11 at the ripe age of 85 years; the deceased gentleman retired from practice in 1873.

We very much regret to have to announce the death of Mr. Charles Forrest Lovibond, L.R.C.P. et R.C.S. Edin., L.F.P.S. Glas., 1888, who died from typhoid fever at Wallsend, near Newcastle, on November 26, at the early age of 29 years; the deceased gentleman was the second son of Mr. Alfred Lovibond, of Bridgewater, Somerset, England, and arrived in the colony only ten months ago.

MR. ELLAR MCKELLAR MCKINLAY, L.F.P.S. Glas., 1837, an old colonist of over 50 years' standing, died at Dungog on November 14, death being the result of an accident. It appears the deceased gentleman, who had been obliged to use crutches for some years, was going up some steps, and, one of the crutches slipping, he fell, striking his head on one of the steps, which caused concussion of the brain. He did not regain consciousness. He was one of the pioneer settlers in the Wilcannia district before coming to Dungog. He was also a great scientist, and one of the greatest authorities in the colonies on the manners and customs of the aborigines. He possessed a very valuable collection of Australian curiosities, gathered during his early travels. He was a brother of the well-known explorer of the same name.

THE following examiners have been appointed to act with the professors in the conduct of the annual examinations at the Medical School of the Sydney University:—Pathology, Dr. Renwick; Materia Medica, Dr. George Bennett; Medicine, Dr. Mackellar; midwifery Dr. P. Sydney Jones; Surgery, Dr. A. McCormick; Ophthalmic Medicine and Surgery, Dr. A. Murray Oram; Medical Jurisprudence, Sir Alfred Roberts; Psychological Medicine, Dr. F. Norton Manning.

THE following medical practitioners have been appointed magistrates of the Colony, viz.: Drs. G. de V. Belson, Tumbarumba; G. R. Eakins, Echuca; S. Finlay, Stroud; R. Hodgson, Croydon; A. J. Hood, Sydney; W. Hull, Sydney; C. H. Scott, Penrith; C. H. Souther, Hillston.

DR. J. R. ANDERSON has commenced practice at Ryde, on the Parramatta River, eight miles N.W. of Sydney.

DR. E. G. BLAXLAND, late of the Prince Alfred Hospital, Sydney, and formerly of Little Bay Coast Hospital, has commenced practice at Burwood, a suburb seven miles from Sydney.

DR. H. M. BLUMENREICH, formerly of Dysart (Scotland), has settled at Warren, 353 miles W. of Sydney.

DR. C. A. DALY has commenced practice at Whitton, 375 miles S. of Sydney.

DR. A. K. HOETS, of Yass, has been appointed captain in the first regiment of the N. S. Wales Volunteer Infantry.

DR. A. G. HENRY, late of the Prince Alfred and Sydney Hospitals, has been appointed Junior Medical Officer at the Hospital for the Insane at Callan Park.

DRS. E. J. JENKINS, R. V. KELLY and C. SWANSTON have been appointed Surgeons on the partially-paid medical staff of the N.S. Wales military forces.

DR. G. L. MULLINS has removed from Macquarie-street, Sydney, to "Avenel," Leichhardt-street, Waverley.

DR. G. S. SAMUELSON, a recent arrival, has commenced practice at Bourke.

DR. B. B. SCHWARZBACH, specialist for diseases of the eye, has removed from Macquarie-street to 140 Phillip-street, Sydney.

DR. W. CAMAC WILKINSON, Lecturer in Pathology at the Sydney University, has been granted leave of absence during Lent and Trinity terms; Dr. G. E. Rennie has been appointed to deliver the course of lectures on pathology during his absence.

NEW ZEALAND.

OVER thirty applications were received by the Hospital Board in Auckland for the post of Medical Superintendent to the District Hospital. Dr. Floyd Collins, of Hokitika, has been appointed to this newly created position.

THE whole of the Medical Staff of the Auckland Provincial Hospital forwarded their resignation immediately the appointment of a Medical Superintendent was made, as they felt that an implied censure had thus been passed upon them, and that the Board had thus intimated that they were not doing their duty properly; they also felt that they had lost the confidence of the Board.

DR. JAS. MOIR has removed from Tauranga to Ponsonby, a suburb two-and-a-half miles from Auckland.

QUEENSLAND.

DR. JAMES CAMPBELL, M.D., Vienna *et* Glas. 1879, L.R.C.S. Edin. 1873, M.B. Glas. 1874, of Ann Street, Brisbane, was found dead in bed on Sunday morning, November 17. He was apparently well on the previous Saturday, but had suffered for some time past from insomnia and nervous irritability, and has relieved this by sedatives. It is surmised that becoming restless during the night he took an overdose by mistake. Dr. Campbell was 44 years of age. He arrived in the colony in 1877, and was formerly Resident Medical Officer at the Rockhampton Hospital, but left that town to visit Europe about ten years ago. He spent some time at Vienna in the study of diseases of the eye, and returned to Queensland about eight years ago, when he settled in Brisbane and practised his profession as a specialist in diseases of the eye and ear.

DR. KEARSEY CANNAN, of Brisbane, has been appointed Official Visitor to the Asylum for the Insane, Goodna, and the Reception House, Brisbane, in the room of Dr. James Hill, who has left Brisbane for Longford, in Tasmania.

DR. G. T. LLOYD has commenced practice at Mackay, and Dr. J. A. Forrest at Rockhampton.

DR. B. RENDLE, late of Brisbane, is now practising at Caboolture, 31 miles N. of Brisbane.

DR. D. W. B. WILKIE has removed from Muttaborra to Charters Towers, he having been appointed Medical Officer of the local Friendly Societies.

SOUTH AUSTRALIA.

THE third reading of the New Medical Bill was carried in the Legislative Assembly on November 12.

MR. WILLIAM BRAIN BAKER, M.R.C.S. Eng., 1882, L.S.A. Lond., 1881, formerly of Kooringa, died suddenly on November 21 from heart disease, on board the barque "Scottish Admiral," which vessel arrived in Brisbane from England some ten days previously. The deceased gentleman was just returning from a trip to England. The reason why Dr. Baker remained on board is, it is said, that he was awaiting the arrival of money from South Australia, in order to be enabled to make the journey to Adelaide. He received the money required duly, and it was his intention to start for South Australia at an early date. He first arrived at Adelaide in 1883, and commenced practice at Terowie. When the Hon. Dr. Cockburn entered Parliament, Dr. Baker removed to Jamestown and conducted the practice for a year. Later he acted as *locum tenens* for Dr. Archer at Moonta for almost a year, and he has travelled as referee for Assurance Societies through South Australia, Victoria and Queensland. Eighteen months ago Dr. Baker left for England.

DR. T. C. BENNETT has removed from Broken Hill (N.S.W.), to Hawker, 275 miles N. of Adelaide.

DR. J. JOHNSON, of Mount Gambier, has been elected first President of the newly established local Floricultural Society.

DR. C. G. LERMITTE, of Salisbury, near Adelaide, has been elected President of the local Institute.

DR. R. H. PERKS, recently appointed Resident Medical Superintendent of the Adelaide Hospital, has arrived from England and taken charge of the institution.

TASMANIA.

DR. J. H. CHAMP has settled at Beaconsfield, an important gold-mining township 32 miles N.W. of Launceston.

DR. T. K. FULTON, formerly of Edinburgh, has settled at Hamilton-on-Forth, 215 miles N. W. from Hobart.

VICTORIA.

THE Central Board of Health has severely censured Dr. Figg, of Williamstown, port health officer, for granting pratique to the steamer "Yarra" when there was a case of modified smallpox on board. Dr. Figg, who was present at the meeting, gave an explanation which the board did not consider satisfactory. Dr. Figg then volunteered to resign in favour of a younger practitioner if granted 12 months' leave of absence on full pay.

THERE was a pleasant gathering on November 12 at the Ballarat Hospital to celebrate the inauguration of the system of the training of female nurses, on the occasion of which the nurses who had passed the necessary examination after the year's course of lectures were presented with their certificates. Dr. Scott (Resident Surgeon) and Drs. Whitcombe (chairman of the honorary staff), Pinnock, Ochiltree, Salmon and Radcliffe, who were present, made appropriate and complimentary speeches.

PROFESSOR DR. ALLEN, of the Melbourne University, has been granted leave of absence on half-pay during the year 1890.

DR. AUBREY BOWEN, of Melbourne, has received the order of Chevalier of the Legion of Honour for services rendered at the last Paris International Exhibition.

DR. J. C. V. DENNING has settled at Macarthur, 244 miles W. of Melbourne.

DR. F. T. W. FORD, of Collins-street E., Melbourne, has left by the R.M.S. "Ormuz" on a trip to England.

DR. S. J. R. GREVILLE, formerly of Albury, has settled at Avoca.

DR. F. HAMILTON KENNY has removed from West Melbourne to Williams-road, Hawksburn, a suburb three miles S.E. of Melbourne.

MR. H. P. SCOTT, L.S.A., late of Phillip-street, Sydney, has commenced practice at York House, Victoria-parade, Fitzroy, a suburban city adjoining Melbourne.

DR. L. S. WELLS has commenced practice at Maldon, 89 miles N.W. of Melbourne.

WESTERN AUSTRALIA.

DR. H. L. SMITH, of Albany, was presented, on November 28th, with a complimentary address, signed by ninety of the leading residents, expressive of their friendly feelings towards him and their hearty good wishes for his success in the future.

PROCEEDINGS OF COLONIAL MEDICAL BOARDS.

The following gentlemen, having presented their diplomas, have been duly registered as legally qualified Medical Practitioners by the respective Boards:—

NEW SOUTH WALES.

Egan, John Joseph, M.B., Ch.B., B.A.O. Roy. Univ. Irel., 1889.
Mann, James, L. et L. Mid. R.O.P. et R.C.S. Edin., 1877.

QUEENSLAND.

Kerr, John Aloysius, M.B. et Ch.M. Glas., 1884.
Lloyd, George Tyndale.
Forrest, James Alexander.
Strangman, Thomas Handcock, L.R.C.S. Irel., 1886; L. et L. Mid. K.Q.C.P. Irel., 1888.
Collins, Michael Joseph, L.R.C.S. Ed., 1882.

TASMANIA.

Champ, John Howard, M.D. Lond., 1884; M.R.C.S. Eng., 1883; L.S.A. Lond., 1882.
Fulton, Thomas Kensington James, L.R.C.P. et R.C.S. Ed., L.F.P.S. Glas., 1887.
Hill, James, M.D. Ed., 1864, L., 1864, F., 1882, R.C.S. Edin.

VICTORIA.

Wells, Lionel Seife, L. et L. Mid. R.C.P. et R.C.S. Ed., 1889; L.F.P.S. Glas., 1889.
Theod. Stanley Vipan, M.R.C.S. Eng., 1880; L. et L. Mid. R.C.P. Edin., 1880.
Scott, Hubert Payne, L.S.A. Lond., 1872.
Manly, Richard Augustus Aloysius, M.B. Melb., 1889.
Joyce, Alfred Fleming, M.B. Melb., 1889.
Robards, Albert Otto, M.B. Melb., 1889.
Saunders, John Harry, M.B. Melb., 1889.
Boyes, William Isaac, M.B. Melb., 1889.
Guthrie, Emil, M.B. Melb., 1889.
Danzman, George William, M.B. Melb., 1889.
Cherry, Thomas, M.B. Melb., 1889.
Peables, Frank Montgomerie, M.B. Melb., 1889.
Fox, John Raymond, M.B. Melb., 1889.
Gregerson, William Jens, M.B. Melb., 1889.
Martell, Horatio Percy, M.B. Melb., 1889.
White, James Purves, M.B. Melb., 1889.

Additional Qualification Registered:

Syme, George A., Ch.M. Melb., 1888.

MEDICAL APPOINTMENTS.

Boodle, George Adolphus, M.R.C.S.E., to be Government Medical Officer and Vaccinator for the District of Walcha, N.S.W.
Denning, John Vere Charles, L.R.C.S. Irel., L.K.Q.C.P. Irel., to be Public Vaccinator at Macarthur, Vic.
Egan, John Joseph, M.B. et Ch.B. Roy. Univ. Irel., appointed House Physician at St. Vincent's Hospital, Sydney.
Greville, Sampson John Rodger, M.R.C.S.E., L.R.C.P. and S. Ed., L.F.P.S. Glas., to be Public Vaccinator for Avoca, Vic., vice Dr. E. Harkness, resigned.
Jennings, Edward, M.R.C.S.E., L.R.C.P. Lond., to be Honorary Surgeon and Surgeon on the General Medical List, New Zealand Volunteers.
Kerr, James, M.B. et Ch.M. Ed., to be Health Officer for the Snowy River, Buchan and Bendoo Ridings of Shire of Tambo, Vic.
McBurney, Robert, M.D. Ed., to be Government Medical and Health Officer at Mackay, Qu.
McGinness, John, L.R.C.S. Irel., L.K.Q.C.P. Irel., to be Officer of Health for Shire of Namurrah, W.B., Vic.
Robinson, Leonard, M.D. et Ch.M. Roy. Univ. Irel., to be Officer of Health for the Borough of Hamilton, Vic.
Salmon, Harry Robert, M.B. et Ch.B. Melb., to be Health Officer for the Borough of Buninyong, Vic.
Shuter, Charles Yaldwin, M.B. Durh., M.R.C.S.E., to be Public Vaccinator at Kensington, Vic., vice Dr. G. D. Dickinson, resigned.
Volkman, Ronald, M.R.C.S.E., L.R.C.P. Ed., to be an additional Public Vaccinator for the District of Thames, N.Z.

BIRTHS, MARRIAGES AND DEATHS.

. The charge for inserting announcements of Births, Marriages, and Deaths is 2s. 6d., which should be forwarded in stamps with the announcement.

BIRTHS.

BOOTH.—On the 27th October, at South Brisbane, the wife of Dr. James Booth, of a daughter.
HANSON.—November 19, at Concord road, Burwood, (Sydney), the wife of Albert G. Hanson, surgeon, of a daughter.
O'BRIEN.—On the 15th November, at Sunbury, Victoria, the wife Dr. J. A. O'Brien, of a daughter.
O'CONNELL.—On the 27th October, at Adelaide, the wife of Dr. O'Connell, of a daughter.
SALMON.—On the 22nd November, at Ballarat East, the wife of H. R. Salmon, M.B. et Ch.B., of a son.
SIMPSON.—November 22, at Lelehard, (Sydney), the wife of R. A. Simpson, M.B. et Ch.M., of a daughter.
SMITH.—On the 3rd November, at Casterton, Victoria, the wife of Dr. Charles Smith, of a son.
STIRLING.—On the 19th November, at North Adelaide, the wife of E. C. Stirling, M.D., of a son.
TUTHILL.—On 29th October, at Euroa, Victoria, the wife of Dr. John Tuthill, of a daughter.

MARRIAGE.

LANE—SELBY.—November 26, at Inverell, N.S.W., by the Rev. Alfred W. King, Dr. Thomas Lane, to Amy Isabel, second daughter of the late William Selby, of Inverell.

DEATH.

BROWNLESS.—November 14, at East Melbourne, Anne Jane, wife of Anthony Colling Brownless, M.D., F.R.C.S., C.M.G., Chancellor of the Melbourne University, and mother of Dr. A. C. Brownless, of Sydney.

A CORRECTION.—In the letter on "Volkmann's Method for Echinococcus of Liver," by Dr. Marano in our last issue, read "ten grammes of fluid" instead of grains.

MR. BRUCK has received a full supply of *Burroughs' Chloride of Ammonium Inhalers* (Vereker's patent) price 10s., also the "Perfect" *Stylographic Pen*, specially for use with the B. W. and C. Prescription Blank Books, and for ordinary correspondence, complete with dropper, in case, 10s 6d.

MR. BRUCK begs to call the attention of the profession to his splendid stock of batteries and electric appliances, a detailed list of which will be found on the fifth page of the *A. M. G.* Advertiser in this month's issue.

REPORTED MORTALITY FOR THE MONTH OF OCTOBER, 1889.

Cities and Districts.	Population.	Births Registered.	Deaths Registered.	Deaths under Five Years.	Number of Deaths from									
					Measles.	Scarlet Fever.	Group and Diphtheria.	Whooping Cough.	Typhoid Fever.	Dysentery and Diarrhoea.	Phthisis.	Heart Disease.	Cancer.	Child-bearing.
N. S. WALES.														
Sydney	132,846	308	183	71	...	...	4	8	2	8	19	14	5	3
Suburbs	215,849	885	316	161	...	...	14	23	5	17	25	19	7	4
NEW ZEALAND.														
Auckland	35,858	91	27	5	...	...	1	...	...	...	3	3	2	1
Christchurch	16,455	39	18	5	...	...	...	...	...	...	2	2	...	...
Dunedin	23,546	54	20	9	...	...	...	...	...	...	2	2	1	...
Wellington	29,075	80	31	11	...	..	2	...	...	...	6	5	2	...
QUEENSLAND.														
Brisbane	51,689	187	119	64	} ...	...	3	7	4	41	8	8	5	2
Suburbs	21,960	152	55	40		...	...	...	...	...	...	...	...	...
SOUTH AUSTRALIA	316,792	814	237	79	...	...	10	...	...	3	30	21	10	...
Adelaide	43,750	69	61	17	...	...	...	...	...	3	10	4	5	...
TASMANIA.														
Hobart	34,924	106	63	10	...	...	2	...	3	...	6	6	3	...
Launceston	21,485	68	44	12	...	...	1	...	2	1	4	6	3	...
Country Districts	91,990	285	74	...	...	...	2	...	...	2	...	...	...	...
VICTORIA.														
Melbourne	75,400	155	88	} 259	...	1	26	15	6	21	82	47	20	8
Suburbs	362,385	1216	557		...	...	...	...	...	...	...	...	...	...

METEOROLOGICAL OBSERVATIONS FOR OCTOBER, 1889.

STATIONS.	THERMOMETER.				Mean Height of Barometer.	RAIN.		Mean Humidity.	Prevailing Wind.
	Maximum Sun.	Maximum Shade.	Mean Shade.	Minimum Shade.		Depth.	Days.		
						Inches.			
Adelaide—Lat. 34° 55' 33" S. ; Long. 138° 36' E. ....	...	88.1	63.5	42.	29.888	...	...	...	...
Auckland—Lat. 36° 50' 1" S. ; Long. 174° 49' 2" E.	135.	74.	58.6	47.	...	3.200	11	74	...
Brisbane—Lat. 27° 28' 3" S. ; Long. 153° 16' 15" E.	158.5	87.6	68.6	49.1	30.090	3.854	11	68	E.
Christchurch—Lat. 43° 32' 16" S. ; Long. 172° 38' 59" E.	145.4	76.2	53.9	32.4	...	0.496	5	64	...
Dunedin—Lat. 45° 52' 11" S. ; Long. 170° 31' 11" E.	140.	83.	53.2	36.	...	1.670	12	74	...
Hobart—Lat. 42° 53' 32" S. ; Long. 147° 22' 20" E. ....	...	79.7	54.8	32.	29.898	2.58	20	77	...
Launceston—Lat. 41° 30' S. ; Long. 147° 14' E. ....	...	77.5	57.4	35.	29.985	4.40	13	81	...
Melbourne—Lat. 37° 49' 54" S. ; Long. 144° 58' 42" E. ....	...	84.5	58.9	37.8	29.935	2.86	11	...	...
Sydney—Lat. 33° 51' 41" S. ; Long. 151° 11' 49" E. ....	...	88.	63.4	48.8	30.068	0.84	11	74	E.
Wellington—Lat. 41° 16' 25" S. ; Long. 174° 47' 25" E.	127.	68.	54.5	41.	...	3.203	16	74	...

AUSTRALASIAN MEDICAL GAZETTE.

ORIGINAL ARTICLES.

WIND INSTRUMENTS FROM A MEDICAL POINT OF VIEW, WITH SPECIAL REFERENCE TO PHTHISIS AND EMPHYSEMA OF THE LUNGS.

READ BEFORE THE N.S.W. BRANCH OF THE
BRITISH MEDICAL ASSOCIATION.

By G. T. HANKINS, M.R.C.S. ENG., L.S.A.,
HON. SURGEON ROYAL PRINCE ALFRED
HOSPITAL, SYDNEY.

MEMBERS of our profession are frequently consulted by parents as to the advisability of letting their children learn some wind instrument, and the advice given is apt sometimes to be contradictory. Some of us may have a feeling that, generally speaking, playing wind instruments is detrimental to health, whilst others consider it acts as a preventive to disease and is always beneficial.

The fact is, before giving an opinion we should know something of the state of health and family history of the individual for whom we are advising, and it is also necessary that we should have some knowledge of the peculiarities of the different instruments mostly affected by amateurs.

We will, if you please, consider for a few minutes the mechanism of respiration.

Inspiration and expiration take place alternately with no appreciable pause between them, and about 16 to 20 cubic inches of air—only a small portion of the whole capacity of the lungs—are exchanged each time. Inspiration is a muscular act in which the diaphragm plays the principal part, and it is aided by all the muscles that raise the ribs. The action of the intercostal muscles is uncertain. Some consider that the external are inspiratory and the internal expiratory muscles; others that their function is simply to render tense the intercostal membranes and thus prevent bulging and sinking from atmospheric pressure during respiration. This function is a very important one, as we shall see when we come to consider emphysema.

Ordinary expiration is not accomplished by muscular action, but the lungs are emptied by their own elasticity, aided by the spring of the costal cartilages which became twisted on themselves during inspiration, also by the weight of the ribs and upper extremities. The elasticity of the abdominal wall is also brought into play, for it

was protruded during the descent of the diaphragm in inspiration and seeks to return to a condition of rest.

Forced expiration is accomplished by the action of the abdominal muscles compressing the viscera and forcing the diaphragm upwards, also by the muscles which depress the ribs, such as the quadratus lumborum. The lungs merely follow the thoracic walls, the air entering and expanding the vesicles when an attempt is made to produce a vacuum by inspiratory effort, and by its exit allowing them to collapse again when that effort is discontinued.

In the schema before you the glass cylinder represents the thorax and the indiarubber bladders, the air vesicles or lobes of the lung communicating freely with the external air by means of gas tubing representing the bronchi and trachea. The cylinder is filled with water (a condition of artificial hydrothorax) to do away with the space between the air bladders and glass wall. The muscular action is imitated by putting on and taking off water pressure by means of the reservoir and syphon. In its present position the pressure is equalized as shewn by the manometer in connection with the cavity of the jar. By lowering the reservoir to the table a minus pressure of 19 inches H.O., and by raising it a plus pressure proportionate to the height is exerted upon the contents. These changes have no effect on the bladders as long as the tap representing the glottis is closed, but when it is opened the bladders expand and collapse with the rising and falling of the reservoir. Note how the thinner bladders expand much more than the thicker ones, as I shall have occasion to refer to that point when I come to speak of emphysema. Observe that when the pressure is equalized the bladders collapse; that is, they require no extra pressure or muscular action to cause them to do so, only their own elasticity and the weight of the water in the cylinder corresponding to the weight of the thorax and upper extremities and the elasticity of the costal cartilages.

Pressure exerted during respiration.—Donders says that in quiet respiration the inspiratory pressure equals *half-an-inch* and the expiratory one to one-and-a-half inches H.O. This is strange, because during health inspiration takes place more quickly than expiration, and for a given quantity of air to be drawn through the glottis the operation which takes least time would seem to require most pressure, accordingly I fancy Donders' ratio should be reversed.

My own observations, which are in accordance with this argument, give inspiration one-and-a-

half, expiration three-quarter in. H.O., or just half.

In forced respiration Donders states that inspiratory pressure may go up to 30 inches and expiratory to 45, a difference of 15 inches. My own observation gives 61 and 60 respectively, again reversing the ratio but with only a slight difference in favor of inspiration; this, however, may be a personal peculiarity. In spite of these observations on pressure there is no doubt that the inspiratory muscles are much stronger than the expiratory, because they have to overcome the elasticity and weight of the thorax and lungs before they can admit any air.

We will now turn from the bellows to the instruments they have to blow.

Those most popular with amateurs are the flute, cornet, clarinet, and oboe, in the order I have given them.

The other instruments which go to make up the wind contingent of an orchestra are, the bassoon, horn, trombone, and tuba, but as these are generally used only by professionals they require but passing notice.

Comparisons have been drawn between the *physique* of wind and string instrument players, to the disadvantage of the latter class, but it must be observed that the majority of wind instrument players are to be found in military bands—in other words are soldiers and accustomed to athletic exercises in the open air. But still I shall be able to show that the practice of wind instruments is of itself conducive to vigour and health.

The Oboe is an instrument with a small conical bore giving what is called a two foot tone for its lowest note. The sound is produced by forcing air through a small double reed, which is nipped by the lips. The pressure required for ordinary playing is from 7 to 13 inches H.O. This result is arrived at by placing a fine tube in the angle of the mouth connecting it with the manometer, and sounding the instrument in the ordinary way.

The oboe is notoriously a very trying instrument, and until I made the experiment I always thought the pressure required to play it was very great on account of the smallness in the aperture in the reed, but in this I was mistaken; the distress is caused by the air escaping so slowly that the lungs cannot empty themselves readily, and the tendency after playing is not to take in more air but to get rid of what has been pent up in the chest.

The Clarinet is a single reed instrument, the reed closing a lateral aperture in the beak or mouthpiece, which is bevelled off towards the point so as to allow of room for the reed to vibrate. Although about the same length as the oboe it

gives a four foot tone for its lowest note instead of a two foot one. This is explained by Helmholtz by the fact of the bore being cylindrical and not conical, thus producing the same effect as a stopped diapason organ pipe, which as you know gives a note twice the depth of an open pipe. This instrument requires more pressure than the oboe (from 10 to 27 inches H.O.), but on account of the larger bore and the freer action of the reed the air escapes from the chest much more quickly, more frequent respirations are taken, thus avoiding the great drawback attending the oboe.

The Bassoon is almost purely an orchestral instrument, the natural bass of the oboe. It has a double reed, but much larger than that instrument; the pressure needed is not great nor is there much impediment to the exit of air. It is a wooden conical tube eight feet long, bent on itself, giving an eight foot tone as its lowest natural note, but it can borrow some notes from the 16 foot octave by use of its extra keys. Both it and the oboe require great skill in the management of the reed, but the latter is more trying to the temper than to the chest.

In the *Cornet* the sound is produced differently, here the lips themselves, being pressed into the cup-shaped mouthpiece, vibrate like the double reed in the oboe and bassoon; the length of the tube is four feet six, but it can be increased by the use of pistons to six feet three. The support given to the lips by the peculiar shape of the mouthpiece allows of great pressure of air being used. As a matter of fact it required from 12 to 54 inches H.O. in order to bring out the full compass of the instrument.

Now 54 inches equals a pressure of 2 lbs. to the square inch. The soft palate, which acts as a valve to prevent the air from escaping through the nose, has about two square inches surface, therefore in cornet playing it has to support a weight of four lbs.

The Flute in its ordinary form is a wooden instrument with a conical bore giving, like the oboe, a two foot tone, the sound is produced by blowing across, not into, a lateral opening with a feather edge; this edge splits the column of air into pulses of different rates of vibration and therefore of tone, of themselves almost inaudible. The tube acts as a resonator, and the column of air enclosed in it vibrates in unison with whichever of the pulses it happens to be in tune and no other, magnifies it and renders it audible. The length of the vibrating air column, and therefore the note, in these instruments, is varied by the extent to which the holes are covered by the fingers.

There is next to no resistance encountered in blowing the flute, the pressure required is from two to seven inches H.O., the latter being

sufficient for the highest notes. Owing to the free escape of air in playing this instrument the lungs require frequent replenishing. Modern flutes have a cylindrical bore (except at the head, which is conical) and very large holes, by which means a much richer tone is produced.

Most wind instruments can be played with impunity by young, vigorous and healthy persons, provided they are taught to respire properly and that the duration of the practices be limited so as to fall short of fatigue until the mastery of the instrument has been attained.

But of those who take up wind instruments all are not so favourably circumstanced as to health and strength, and it behoves us to consider the dangers to which they may be liable.

Amongst those most frequently enumerated may be mentioned hernia, apoplexy, amaurosis, heart disease, phthisis and emphysema of the lungs. And I should like to devote a few minutes to the consideration of the latter disease, especially as I shall be able to illustrate the phenomena to some extent by means of this model.

I would remind you that there are two theories of *emphysema*, the inspiratory and the expiratory, the former is principally advocated in Great Britain by Professor Gairdner, the latter by Sir William Jenner.

Professor Gairdner says the *inspiratory* theory is sufficient to account for all the phenomena found in emphysema. To explain these phenomena in this way he takes for granted that there is a previous weakening in the tissue of the air vesicles either from hereditary causes, as gout, chronic inflammation as in bronchitis, general malnutrition, or collapse of certain portions of lungs as in whooping cough.

As will be seen in this model when forced inspiration is made, the air bags distend themselves and can easily be made to burst. But Sir William Jenner states that in the human subject muscular action in forced inspiration is never sufficient to injure the air vesicles. We must believe, however, that if their elasticity is impaired they will not regain their former size after such an effort.

You observed a little while ago the unequal dilatation of the several sacs. We will suppose these thicker ones to be diseased, collapsed or thickened by inflammation; in this case the others have to compensate for their want of elasticity, and easily become overstretched; thus a condition of emphysema is started.

Now it is said, and cannot be gainsaid, that severe work on certain wind instruments causes emphysema. I have been unable to find any cases recorded where the disease was distinctly traced to this cause. But a cornet-player in this city tells me that some years ago he had to play

for as many as eight hours a day, and that since that time he has never been able to run upstairs without becoming short of breath. It is an undoubted fact that omnibus horses and working bullocks are liable to this disease (otherwise called broken wind) from the constant straining in starting heavy loads. To account for this fact we shall be compelled to call in the aid of the *expiratory* theory.

Sir W. Jenner says that the conditions necessary for emphysema are violent expiratory efforts with closed glottis. Let us imitate this action on our schema. First of all inflate the lungs, then close the glottis and exert expiratory pressure. What happens? Hardly anything. As soon as the air in the bladders becomes a little compressed, thus diminishing the tension of the membrane, a condition of equilibrium is established, and no amount of pressure or sudden opening of the tap thus imitating cough, will affect the size of the bladders. The reason for this is that they are evenly supported on all sides by the water pressure. How do the lungs get this equal support in the human thorax? Jenner points out that they do not, and that the emphysema occurs just in those portions which are wanting in that support. These are the apices which are only supported by the soft parts at the root of the neck, the free edges of the lungs, and those portions that rest against the trachea and the intercostal spaces (we now see the necessity of the intercostal membranes being kept tense by their muscles.) Wherever the chest wall bulges on expiratory effort, the exit for air being closed, there will the air cells suffer distension, and no where else. If this distension is excessive, takes place too frequently, or lasts too long, emphysema is the result. When once the disease has been started in this way, and a certain number of air vesicles fail to empty themselves, a craving for more oxygen is felt by the system, and increased inspiratory efforts are made to satisfy it. This tends still further to undue expansion of the lungs, and a vicious circle is entered upon. It thus appears that emphysema may be caused in different ways, and that neither theory alone is sufficient to explain all cases.

Now high intra-thoracic pressure tends to prevent the return of blood into the large veins of the chest, resulting in congestion of the head with risk of rupture of blood vessels in the brain, also of the retina, leading to amaurosis. Then great pressure in the region of the pharynx is likely to cause irritation and catarrh of the mucous membrane, with cough, often regarded as phthisical. The possibility of hernia as the result of straining requires no comment.

From my foregoing comparison of the different instruments, and review of the dangers likely to result from constantly subjecting the lung and air passages to high pressure, you will gather that I consider the instrument *par excellence* for the young amateur to be the flute. Its practice is not only free from danger, but may be indulged in with positive benefit to the health. The pressure is very slight, the position of the body is good, and the respirations free; I have frequently played for three hours at a stretch without any inconvenience, if I may except a crick in the neck from holding the head so long in one position. During flute-playing the renewal of the air in the lungs is frequent, and the inspiratory action without being excessive is sufficient to bring into play the apices of the lungs, those portions which on account of their usual inactivity and consequent low vitality are the seat of election for tubercle.

Flute-playing is a capital substitute for walking exercise, when from accident or local disease this is impossible, and I can answer for its promoting appetite and raising the spirits in a way it would be difficult to find excelled by any other sedentary amusement.

On account of the necessarily rythmical character of the respirations wind-instrument practice ought to equal elocution and singing as a cure for stammering.

Practice should always be discontinued on the occurrence of the slightest catarrh, and the peculiarity of the tone produced will often be the first indication that cold is coming on, the tone in the early stages being often improved.

Lest it should be thought that a personal preference for the instrument may have induced me to run my hobby too hard I might explain that, personally, I prefer playing the Clarionet, as giving me more satisfaction as regards expression and quality of tone, but there is no doubt it requires greater exertion to play, more constant practice to keep up a fair average of proficiency, and has, moreover, the disadvantage of being less easily tuned to the pitch of other instruments.

The *Oboe*, though not requiring so much pressure as the Clarionet, necessitates the chest being kept full for a longer period than is physiologically desirable, the result being want of æration of the blood, and the risk of the elasticity of the air vesicles being impaired in consequence of the mechanical anæmia caused by prolonged pressure on their capillary net-work.

The *Cornet* I regard as a very trying instrument unless the player is content with moderate effects, and does not strive at very high notes or *forte* passages.

In conclusion, I will give you the opinion of one or two authorities on the effect of wind instrument playing generally:

Alfonse Saxe, jun., Paris, the inventor of the Saxhorn, Saxophone, and other military instruments, says that three only of the many thousand workmen employed from time to time in testing their instruments have died of consumption, and these unfortunate men were addicted to excesses of all kinds.

That he was one of a family of eleven, all of whom, with the exception of three, died of consumption, and these were early in life taught to play wind instruments.

That he was never ill but once in his life when he had to give up the flute on account of some trifling injury, and he only began to make a rapid recovery when he was allowed to resume his instrument.

Dr. Burg says that his mother and eight of her children died of consumption, three surviving, who played wind instruments from an early age.

Dr. Scot-Skirving informs us that in the Highlands it is an old woman's yarn that those who play the bagpipes never get consumption.

Dr. Jenkins gives an instance of a contracted chest being expanded and developed by practice on the Highland bagpipes.

I thank you for the patience with which you have listened to my paper, and venture to express a hope that the playing of wind instruments, with proper precautions, may take a prominent place in the preventive treatment of Pulmonary Disease.

NOTES ON A CASE OF INGUINAL COLO TOMY.

READ BEFORE THE N.S. WALES BRANCH B.M.A.
BY W. D. CAMPBELL WILLIAMS, L.R.C.P.
LOND., M.R.C.S.E., BRIGADE-SURGEON
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I HAVE the honor to bring before you this evening the notes on a case in which I performed the operation of inguinal colotomy a few months back, presenting as it does one or two points which may be of some interest to us.

B. S., aged 52 years, a labourer, was admitted early in May, 1889, to St. Vincent's Hospital. He sought admission from the trouble he experienced in defæcation, which had gradually been progressing from bad to worse for nearly five months, and he also suffered from pain in a most severe form after each motion, the pain lasting in

some cases for a couple of hours. His general condition was poor, the face having an anxious look; weight, 11 st. 2 lb.

An examination of the rectum revealed a condition of epithelioma high up in the bowel, the true condition of which could only be recognized by an examination under chloroform. Under the anæsthetic a hard irregularly-edged nodular mass was felt encircling the bowel, and the tip of the forefinger was admitted with difficulty; no perceptible glandular enlargement; discharge from bowel not profuse, but constant; hæmorrhage only slight.

At a consultation the operation of colotomy was decided on, and for choice I selected the inguinal operation so ably described and recommended by Mr. Harrison Cripps.

On the 21st May, 1889, the patient was placed under chloroform, and with the assistance of Dr. Chisholm I commenced the operation, making the incision as recommended by Mr. Cripps, viz., an incision made at right angles to an imaginary line running from the umbilicus to the anterior superior spine of the ilium, distant one-and-a-half inches from the spine. The length laid down for this incision is two-and-a-half inches, but in this case a longer one was made by nearly an inch and I believe with a distinct advantage, for in a later stage of the operation, when the fine sutures are passed through the muscular coat of the bowel and the skin structures, a greater amount of room is given for adapting the bowel to the angles of the wound without decreasing the exposed surface of the bowel through which eventually the artificial opening has to be made. Nothing of note transpired until the peritoneum was opened, and then the small bowel was found presenting. This condition is said to occur in about two-thirds of the cases operated on. The small bowel was pushed back and on one side, and the colon found without difficulty. There was no chance of mistaking it, shewing up as it did with its well-marked muscular bands. About three inches of loose bowel was drawn down from above and passed downwards, and then the bowel felt fairly tense. Two silk ligatures were then passed through the longitudinal muscular band opposite the colon's mesenteric attachment about two inches apart. The parietal peritoneum was secured by three sutures on each side to skin only, and when the bowel lay *in situ* the upper longitudinal muscular band appeared right down the mid-line of the incision. After a slight rotation of bowel the lower longitudinal band was found, and this was fixed to the parietal peritoneum and skin by nine sutures, one in each extreme angle, and one running right across the bowel at each end, and by fine sutures

spread over a length of about one-and-a-half inches. These latter were simply passed through the whole width of the muscular band. A second series of sutures was passed through the muscular wall of bowels close to mesenteric attachment. The operation as described by Cripps does not allow for any suture at the extreme angles, but I believe that one in that position must act as a safeguard in case the suture which is placed across the bowel should break away. Fine carbolized catgut was used throughout, and when they were all tied in position there was about one-and-a-half inches in length of gut shewing through incision; wound dressed with protective and dry gauze with flannel bandage; operation occupied 55 minutes.

On the next day pain was complained of about wound; no vomiting; patient kept under influence of opium.

Wound dressed two days after operation and looked well; no tension on any of stitches, although pain was still complained of in neighbourhood wound; vomiting absent, but flatulence troublesome; relieved with charcoal given in form of powder 72 hours after operation.

23rd.—Temp. ran up to 100°, and on the following day to 101°8, and for the three subsequent days fluctuated between normal and 100°4, when it again became normal and remained so. I was unable to find any reasonable cause for this rise.

24th May.—On dressing wound lymph was seen to have been abundantly poured out; rapidly filling up the wound.

28th May.—Seven days after operation bowel was opened between the two silken guides which had been originally put in, but before this could be done a large amount of poured-out lymph had to be cleared away. The opened-up edges of the bowel were trimmed off in a curved manner. On opening the bowel I was struck with one point, and that was the close proximity of the two mucous surfaces of the bowel about the centre of the incision, so close, in fact, that without care, the opposite wall of membrane could easily have been injured. This really formed a spur, on the necessity of which so much stress is laid, not only for the immediate success of the operation but for the after comfort for the patient, for, without this spur, the fæces would simply find their way into the lower portion of the bowel, and the patient's condition would be as bad as before the operation. Mr. Allingham insists that two-thirds of the bowel, as exposed and sutured in Cripps' operation, is not sufficient to form a good spur; but, in this case, not only was the spur well-formed when the bowel was first opened but it remained so, and no fæces passed down below it. Several hours after opening the bowel a considerable

quantity of hæmorrhage took place, although at the time there was no bleeding to speak of. A good deal escaped under the dressings before it was noticed. All the stitches were removed on 31st May, or ten days after the operation. Vomiting only occurred once, and that was on the eleventh day—principally bile—and gave no cause for alarm. The opening in bowel was plugged with a small conical-shaped sponge, which was easily retained and effectually prevented any great contraction of the bowel.

The patient was able to pass well-formed motions through the artificial opening without any prolapse of bowel, the mucous membrane being simply everted. He rapidly picked up in general condition, and was discharged on 13th July. The pain about anus and adjacent parts having nearly disappeared, and long walks could be taken without any sense of discomfort. The mucous membrane of the bowel was easily retained by a square pad of lint, supported with adhesive plaster and a bandage.



From a photograph taken one month after the operation.

The last I heard of the patient was about a fortnight ago. He expressed himself then as being in good health, and his state that of general comfort.

A CASE OF TREPHINING FOR EPILEPSY.

UNDER THE CARE OF B. POULTON, M.D.,
M.R.C.S., HONORARY SURGEON ADELAIDE
HOSPITAL.

JOHN C., married, æt. 25, dairyman, residing at Parkside, admitted September 12, 1889, said to be suffering from epilepsy.

History.—Ten months ago, whilst going his rounds as a dairyman, he fell from his cart, owing to the horse bolting as he was standing on the step, fell backwards on his head, but got up soon after and caught the horse. Did not feel very ill at the time, but returning home fell unconscious on the floor. Afterwards remembered falling from the cart and catching his horse, but nothing further for hours after. Dates his present malady from the time of the accident.

Had been in the habit of taking alcoholic stimulants at times. Had taken a glass of rum and milk the morning of the accident. Thinks he had a fit 14 days after the accident. During the five months following his fall had several fits, he does not know how many.

On the 16th March last, after stabling his horses at night, dropped down in a fit and was unconscious for 48 hours. Heard that he was in convulsions nearly all the time. Was laid up for the following six weeks. Says he has since had frequent fits, mostly at night; has no aura. On returning to consciousness feels pain in the frontal region.

Patient had an attack of fever eight years ago, and received five years back a severe blow on the back of the head from a horse-rake, but experienced no bad effects therefrom. Has at times taken alcoholic fluids to excess. Married three years ago, his wife has borne him two healthy children. Says he has had no mental disturbance apart from the fits. There is no history of syphilis, rheumatism, or gout.

His father died of phthisis at 40 years of age; his mother of heart-disease at 38. Both were of temperate habits. There is no history of falling sickness in the family.

Dr. Cleland kindly supplies the following notes from his case-book at the Lunatic Asylum:

"J. C., admitted February 25th, 1889; discharged March 4th, 1889.

"*General Health.*—Not robust; face pale and eyelids dark; body badly nourished.

"*Mental Condition.*—Talks rationally and quietly, but cannot remember having done certain acts with a razor and oxalic acid, although such was the case. Accounts from wife of nocturnal

convulsive seizures. The explanation is probably that he suffers from state of post-epileptic unconsciousness. Patient was sent to the asylum for attempting suicide with a razor, and for general acts of violence at home."

Condition after admission to hospital :

On the night of admission had two epileptic seizures, and four on the following night.

His general appearance is not remarkable in any way; he is fairly well nourished, is intelligent, and his thoracic and abdominal organs are apparently normal. There is nothing to suggest onanism. The urine is clear, acid, sufficient in quantity, and contains neither albumen nor sugar.

My friend, Dr. J. Davies-Thomas, the corresponding physician, kindly examined the case ophthalmoscopically and found nothing abnormal in the fundus. He concurred with the proposal to trephine.

Put on 15 grain doses of potass : bromid : t.d. On the third day after admission I examined his head carefully, and finding a depressed area about an inch-and-three-quarters directly above the left auricle pressed firmly on it with my finger. The patient complaining of some pain I continued the pressure with greater force when he became unconscious, and was seized with very strong tonic convulsions and had to be held in bed : opisthotonos. He was quite insensible; his pupils dilated; the conjunctivæ did not respond to tactile stimulation. The seizure lasted about a minute, and was followed by a period of exhaustion. He had five similar seizures the following night in rapid succession, and fell out of bed on to the floor.

During the next three days he had two fits.

On the 18th he was shown to the staff in consultation, and a fit induced by pressure on the depressed spot.

Twelve fits were recorded during the next six days.

On the 25th he was anæsthetised with ether and trephined; the disc of bone removed included the small area of depression, about two lines in diameter situate just behind the coronal suture, and immediately above the temporal fossa. There was no corresponding indentation of the inner table. The skull was of average thickness. The operation was conducted with full antiseptic precautions; the dura mater was very vascular and bled freely at one injured point; there was no bulging of the membranes; the bone was not replaced; the scalp-flap was fixed with horse-hair sutures after a small drain had been inserted.

Three nights after operation became suddenly violent, and had to be tied down in bed (6 p.m.) At 10 o'clock asked why he had been tied down,

and said he did not remember the occurrences of the early evening; wanted to know if he had been convulsed; four days after the operation all sutures were removed, and the tube was taken out on the seventh day.

On the 11th day the wound was soundly healed, and he was sent out dressed into the garden on a wheeled chair.

Five days after being trephined he had a sudden attack of pain all over the head and his face flushed, but he remained sensible and was not violent. He was put on 30 grain doses of bromide of soda twice a day with 40 grains at night; this was continued for nine days.

On October 12 he was noted as perfectly well, and quite free from any head symptoms; no headaches, no fits, no mental disturbance: has had no bromide since the 9th inst.; has been going about and out on pass to do a little business; to go home and warned not to take any alcoholic drinks.

Was readmitted two days after discharge, brought by a man who said he had fallen off a tram-car that afternoon and had lain unconscious sometime after.

On admission was confused, lethargic, and complained of head-pain. His pupils were dilated, equal and sensible to light; there were twitching of his arms and his facial muscles. Kept in bed for a week and put on the bromide of soda; allowed out on pass on the 11th day, he returned intoxicated, violent and noisy, and had three convulsive attacks in course of the evening; was kept in two days without further manifestations and then discharged.

November 14.—Has called at my house to report himself quite well and to say he has had no further head trouble or any sort of fit. He looks well and strong.

Remarks.—This case did not present every symptom of true epilepsy. There was no aura; no cry before the attack; no laceration of the tongue. During the fits, however, he was quite unconscious, and his mental and bodily condition afterwards were that of an epileptic. I do not doubt that alcohol was at times an exciting cause, but there was no alcoholism at the time of his first admission, nor during the period of his first stay in the hospital, either before or after operation. The clear history of fits following severe head injury with the presence of a depressed tender spot on the vertex suggested traumatism as the main factor indetermining the seizures. This view was much strengthened by the fact of a definite and undoubted epileptoid fit occurring on firm steady pressure with the finger on the tender depressed spot. Nothing abnormal was found except the great vascularity of the dura mater,

which may have been a consequence of the anæsthetic (ether). Recovery from the operation was rapid. The temperature chart does not record any rise over 99°. The man has resumed his work and promised to become and continue a total abstainer.

ON TWO UNPLEASANT PILOCARPINE SYMPTOMS.

BY SHIRLEY ROBERTS, M.R.C.S.E., L.K.Q.C.P.,
IREL., OF ROMSEY, VICTORIA.

As the above-mentioned drug is gaining in popularity with the profession, and fresh proofs of its efficiency are day by day being received, it may not be amiss if I give a short account of some most distressing symptoms I have seen it occasion.

I use the drug a good deal in practice, as I think it can nearly always be relied upon to do what is asked of it; and our *materia medica* is not overburdened with remedies in which the practice at all comes up to, or even approaches, the theory.

A symptom I have seen the drug produce in some half-dozen cases was a most intense burning pain in the glans penis. My attention was first drawn to this about six months ago, when I gave hypodermically gr. $\frac{1}{3}$ of the pure alkaloid to a young man (æt. 18) who was suffering from jaundice. The liver was greatly congested, the temperature 102.3° when first seen, the skin harsh, dry, and markedly icteric. Five minutes after the pilocarpine injection profuse sweating came on, and two minutes later the patient complained of pain in the glans penis, which speedily became so intense that he writhed in agony. The pain lasted twenty minutes and then gradually subsided, the diaphoretic effect continuing for a couple of hours. The next case in which I saw this symptom was that of a gentleman, æt. 34, who had acute nephritis. When I first saw him he was apparently verging on uræmic coma, and showed low muttering delirium. As the most rapid means of elimination were of paramount importance, I at once injected gr. $\frac{1}{3}$ of pilocarpine with gr. $\frac{1}{10}$ of digitalin, besides employing the usual routine treatment. The drugs acted rapidly, but shortly afterwards the patient commenced to rub the glans penis and finally clasped it tightly, being evidently in the most acute pain. The foregoing cases put me on the *qui vive* regarding this symptom, and it was not long before I had another opportunity of seeing it. In this case—pulmonary congestion in an elder brother of the first-cited case—exactly the same effect was produced by gr. $\frac{1}{4}$. I then injected gr. $\frac{1}{3}$ into my own arm, and ten minutes after-

wards had a most distressing corroboration, the pain reminding me of what is frequently noticed in cases of stone.

I have not seen the symptom noticed before, and would like to hear some explanation of it. Have any of the *Gazette* readers had a similar experience?

Whitla says that when given by the mouth the effects of the drug are not so constant as when given hypodermically. I have twice lately had ample proof of this, the patients both undergoing a most profuse and disagreeable salivation, whilst the diaphoretic effect was very slight. One of these, a female, was twice given the drug at two months interval, the salivation being even more decided on the second occasion. I shall in future always use the drug hypodermically.

ANTIPYRESIS.

READ BEFORE THE SYDNEY UNIVERSITY MEDICAL SOCIETY ON OCTOBER 11, 1889.

BY C. G. WILSON.

It is only in recent times that antipyretic methods of treatment have come to be generally adopted. The physicians of the Middle Ages regarded fever as an effort of nature to restore health by burning up noxious substances which had obtained an entrance into the human body, and that therefore the pyrexia was not to be lightly interfered with. Galen, it is true, understood the value of cold drinks and cold baths, and expressly recommended their use in cases of fever. But with the fall of Rome in the fifth century, and the destruction of European civilization which ensued, ignorance became once more supreme, and spread its dark pall over medical science as over everything else. There arose a dread of fresh air and cold water. Want of cleanliness was a thing to be striven after, and holiness seemed to be inconsistent with frequency of ablution. It is not to be wondered at that the treatment of fever underwent a radical change. So far from any effort being made to diminish the patient's temperature he was immured in close rooms, and the heat of his surroundings even increased with a view to promote the critical separation of the morbid matter. During the seventeenth and eighteenth centuries the use of cold water was gradually revived. James Currie, of Liverpool, who flourished at the end of the eighteenth century, is the founder of the systematic cold water treatment of fever. But after his death his method fell out of use, to be replaced by an utterly unscientific and irrational use of water as a panacea for all the ills that flesh is heir to. "Nowadays," writes Mauthner in 1836, "body and spirit are flooded with water ;

water has become a universal remedy; every creature washes, bathes, writes; one half of literature floats in water." It was the swing of the pendulum in the other direction, but it has prepared the way for the adoption in our time of a scientific use of the cold water treatment. Brand, of Stettin, in 1861 inaugurated a new epoch in the history of the treatment of fever, and he was quickly followed by Jürgensen, of Kiel, in 1866. Since then the method has been extensively adopted throughout Germany, and at the present time is the routine treatment throughout the length and breadth of the land. It has also extended to the South of France, and has been given a fair trial by a few English physicians, notably Dr. Cayley, of the Middlesex Fever Hospital, who has recorded his experience in the Croonian lectures for 1880, and who speaks in glowing terms in its favor. But though the subject has been much discussed of late years, yet at the present time there is nothing approaching unanimity on the subject. Anyone who has impartially studied the matter cannot fail to be struck by the fact that while those in favour of the treatment have given it a more or less extended trial, its opponents, without exception, have been deterred from the experiment by *a priori* considerations. I do not say that some of them have not occasionally tried the effects of the treatment in severe cases of fever to meet the accidents of hyperpyrexia, but from an over-estimate of its dangers they have waited till the patient has arrived at an advanced stage of prostration. In such a case antipyretic treatment can do little good, and its more efficient methods are as dangerous as any other kinds of shock.

Every mammal, man included, quickly dies when once the temperature of the body, whether artificially or spontaneously induced, has risen 9 or 10° F. above its normal height. And a rise of 4 to 7° F., such as usually occurs in severe cases of fever, gradually brings about the same result. The deleterious action of the high temperature consists essentially in an induction of parenchymatous degeneration of the tissues and organs. In consequence of this degeneration there arises a diminution in the power of the tissues to resist injury, and also an impairment of the functions of the organs. Among these functional disturbances the most important are those of the heart and brain, which if they result in paralysis of either organ necessarily cause death. These are the deaths attributed to the intensity of the febrile process. It seems to be quite rational, then, that we should obviate these effects of pyrexia by keeping the temperature below a dangerous limit.

It cannot be too forcibly impressed upon you that the treatment is merely prophylactic against

these well-known effects of continued fever, and is not curative in the slightest degree. Antipyretic treatment does not shorten the life history of the fever by a single day. In fact statistics go to show that there is a slightly increased tendency to relapse in cases of typhoid fever so treated. Modern pathologists are agreed that the fever is not a morbid entity but merely a symptom. But inasmuch as all our endeavours to find a specific remedy which shall strike at the exciting cause have been fruitless, our plain duty is to treat a symptom which we have seen to be dangerous to life. And the result justifies our expectations in the marked diminution of mortality which ensues. In the great majority of cases in which efficient and systematic antipyresis is resorted to, the signs of cardiac debility and other typhoid phenomena which may, more or less justly, be attributed to the effects of pyrexia, do not appear at all. A resort to antipyresis as recommended by most English authorities on fever, in cases only of extreme and long continued hyperpyrexia, where the organism is already debilitated from that very cause, is inapplicable from the dangerous effects of shock. And inasmuch as we can never tell beforehand the extent and progress of any case of fever, the plain indication is to resort to systematic antipyresis whenever the temperature rises above a dangerous limit.

The healthy organism is kept at a uniform temperature by two factors, the one being the regulation of the *loss* of heat, and the second the regulation of the *production* in proportion to that loss. It is so in febrile conditions also; but this regulation of the temperature is maintained with regard to the higher temporary elevation of the febrile process. When there is an increased loss of heat there is a corresponding tendency to the increased production of heat. For this reason mild measures are insufficient to lower the temperature, but by very active abstraction the increased production of heat, the regulation of which is not as efficient as in health, becomes inadequate and the temperature is sensibly lowered. There is it is true a tendency for the temperature to rise again, and the more rapidly the more severe and obstinate the fever is. The great results of the treatment are only to be obtained by a steady control of the temperature and a resort to antipyretic measures as often as it tends to rise above a dangerous limit.

There are two great methods of preventing an undue rise of temperature, the one acting by diminishing the production of heat and the other by increasing the loss. From a theoretical point of view the first method is the more scientific of the two, but the distinction is of only subordinate importance. In practice the danger from an

excessive temperature is always so imminent that the most certain and rapid means of lowering the temperature are to be preferred; and in many cases it is still uncertain whether the resultant lowering is not as much due to diminished production as to increased loss of heat. I shall first mention briefly those measures which seem to act principally by limiting the production of heat.

Foremost comes the golden rule of absolute rest to mind and body. Experience has shown that the tendency to a severe type of fever, and therefore to a fatal issue, is greatly increased in those patients who have striven against the onset of the febrile process.

Of equal importance is careful attention to dietetics. Clinical experience since the days of Hippocrates has agreed that solid food is inadmissible in fever. Liquid food must be given in small quantity and at frequent intervals. Milk is most suitable, supplemented with gelatine and the various meat infusions. Alcohol is a food of the greatest value, but it should be reserved for special cases where the debility is marked and the digestive powers also feeble. It is more readily metabolized than other foods and it has also an antipyretic action.

Certain drugs taken internally diminish the temperature. Of these quinine has been longest in use, especially in fevers of a malarial type where it seems to have a specific action. To obtain an antipyretic effect in other febrile disorders much larger doses must be given. The reaction is slow, and observers are divided as to its utility. Murchison did not find it of the slightest use in typhoid and typhus fevers, but other competent observers have obtained good results.

Salicylic acid and its compounds have also been extensively used, more especially in the treatment of acute rheumatic fever. But it is not an efficient antipyretic in other diseases. In the last few years a great stimulus has been given to the subject of chemical antipyresis. It had long been known that a substance, quinoline, with weak antiseptic and antipyretic qualities could be obtained from quinine by the action of caustic potash. Here the matter rested till 1881, when Skraup discovered that quinoline could be prepared synthetically from cheap and simple substances. It then became a question of great interest whether the quinoline so obtained could not be reconverted into the costly alkaloid quinine. The result of the experiments which ensued was the discovery of a number of chemical products with marked antipyretic qualities. Of these the more important and best known are kairin, antipyrin and antifebrin. These substances act more rapidly than quinine and reduce the tempera-

ture still more efficiently. But their effect is correspondingly evanescent, and in a large number of cases symptoms of dangerous collapse have been produced by their use.

Their use has been extended widely during the last few years, and while opinions still differ as to their value, the balance is in their favour. They are especially valuable in cases where the bath is contraindicated from the movement and shock which it entails, or where in private practice the patient and his friends have an insuperable objection to the cold water treatment.

I come now to speak of those methods which act more especially by the direct abstraction of heat, and while I regard their employment as the essential basis of the antipyretic treatment, yet the physician who is most eclectic and does not confine himself to one method of treatment alone, will achieve the most success. Direct heat abstractions are to be commended in the great majority of cases, for they act more efficiently and are more under control. The great difficulty in the use of chemical antipyretics is to know when to exhibit them, in order to prevent a rise of temperature. Idiosyncrasy has also to be considered. What would be a small dose to most persons may produce dangerous symptoms of collapse in special cases. Besides, we may not always be in a position to command these costly drugs. For these reasons I am inclined to believe that the continued inhibition of temperature by the use of drugs is a vain thing, and that their use should be reserved only for cases of emergency, or for special cases where other measures are inapplicable.

In this connection it is interesting to note that the natives of New Britain and other Pacific Islands are accustomed to treat cases of fever by bathing in the sea. The various methods of abstracting heat from the body differ only in degree. Most efficient, perhaps, is the cold bath, in which the patient is immersed in water at from 60° to 70° F., and kept there five to ten minutes. Heat is lost most rapidly in the first few minutes, hence more is gained by frequent repetition of baths of short duration. Brand's rule, which is usually followed, was to resort to the bath whenever the temperature rose above 102.2° F., taking the temperature in the axilla every two hours; hence in severe cases the bath is repeated eight to twelve times in the twenty-four hours. Prolonged shivering is an indication that the patient has been long enough in the bath. Children—in whom the relative extent of heat-losing surface is greater—require a shorter immersion. Where the action of the heart is feeble the cold bath may give rise to dangerous shock, and the patient must be placed in water at 95° F., and the bath gradually cooled by the addition of cold water or

ice. Cold affusions were used by Currie, but they are less effective than the bath in reducing the temperature, and are more disagreeable to the patient. They are specially indicated where it is required to stimulate defective respiration.

Cold packing is the least unpleasant method, and patients consent more willingly to its use than to that of the cold bath. It is to be commended in private practice, but in hospitals the cold bath is preferable as involving less trouble, and as abstracting heat more rapidly and efficiently. The pack is especially valuable in the case of children. Weaker methods of heat abstraction, such as cold sponging, &c., are not to be despised in slight cases, and they are comforting to the patient.

The effect of antipyretic treatment varies according to the time of day. The typically continued fever, like typhoid, has a tendency to morning remissions and evening exacerbations. If the treatment be applied where there is a natural tendency to a fall in the temperature the effect produced is greater. Now, we know that even high degrees of pyrexia can be borne if they are followed by corresponding remissions. The practical indication is, that in order to produce the greatest possible antipyretic effect we should prescribe our antipyretic medicines in the early hours of the evening, and use direct heat abstractive methods between the hours of midnight and morning.

We should select the weakest part if we wish to make a satisfactory breach in the fortress of the pyrexia. At the present day we believe that most of the febrile processes are due to the presence, in the body, of lowly forms of life. Now, Heidenreich, of St. Petersburg, experimenting in 1876, with the spirillum of relapsing fever, the *Spirochaeta Obermayeri* discovered that its vitality was greater at a temperature of 60 to 70° F. than at blood heat, and that it was rapidly destroyed by a hyperpyrexia temperature. May not this be a confirmation of the belief of the older physicians deduced merely from theoretical considerations, that the fever was the means by which the body was to free itself from the *materies morbi*. This conception of the import of fever would be a weighty objection to that form of antipyretic treatment which seeks to prevent the temperature from ever rising at all, but it would not affect the method sketched here, in which it is sought merely to strengthen and prolong the remissions and so prevent the ill-effects, not so much of hyperpyrexia as of continued hyperpyrexia. By giving the baths in this way it is found that a smaller number are necessary, and it is less disagreeable to the patient to have them thus concentrated than distributed more equally over the

whole twenty-four hours. No doubt antipyresis, as so carried out is very irksome to the attendants, but the welfare of the patient must always have prior consideration.

A homiothermal organism seems to suffer no harm from cooling of its body so long as its temperature does not sink below the normal. Many patients suffer from nervous dread of the bath at first, but this generally ceases after the first immersion. Where it persists the exhibition of a little stimulant immediately before the bath, especially if combined with a little morphia, will have a most wonderful effect in obviating this fear and discomfort. The only absolute contra-indications to the use of the bath in typhoid fever are perforation and hæmorrhage, and that from the necessity for absolute rest. It is in these cases that the chemical antipyretics will be found of the utmost value assisted by local applications of ice. In cases of advanced cardiac debility the gradually cooled bath must be employed. Typhoid fever when treated by the systematic use of the cold bath, seems to be a different disease. The pulse rate usually continues moderate throughout the progress of the fever, and there is not the same tendency to cardiac failure which results in the hypotaxes and thromboses seen so frequently when the expectant treatment is resorted to. The so-called typhoid symptoms so well known to, and so justly dreaded by, all who have seen much fever, rarely develop. I have been through the fever wards of the Brisbane Hospital, where Brand's treatment in all its details is carried out, on many occasions, and I was struck by the absence of delirium and other nervous phenomena. And all who have had any experience of systematic antipyresis have been struck by the same fact. As Jürgensen says: "The very appearance of the typhoid patient is the best recommendation of the cold water treatment." It was at one time a matter of apprehension lest the use of the bath should encourage the appearance of affections of the respiratory tract from congestion or determination of blood to the internal organs. But statistics show rather a diminution, and this is due to the maintenance of the action of the heart, and also to a reflex stimulation of the respiratory centre. During the bath the respirations become slower and deeper. If bronchial catarrh be present there is, it is true, considerable coughing, but this serves rather a salutary purpose in clearing the tubes and so preventing a tendency to the plugging and collapse which end in bronchopneumonia. Nervous symptoms are favourably influenced, delirium frequently disappearing after the first bath. Headache is relieved and insomnia is almost unknown, the patient often requiring to be waked for his bath. The tongue keeps

moist, and fœces does not collect in the mouth. The appetite and digestion are less impaired than in other methods of treatment, and food is best given immediately after the bath when the temperature is lowest. At first sight the congestion of internal organs would seem to predispose to rupture of arteries and hæmorrhage, but this increased tendency to rupture is quite balanced by the prevention of fatty degeneration of the vessels and organs. The cold bath causes copious diuresis. Now Murchison used to believe that the nervous phenomena vaguely grouped under the name of typhoid symptoms were uræmic in origin, and the cold bath treatment may derive part of its great value in preventing their development from its undoubted diuretic qualities.

I do not suppose that at the present day there is any great centre of medical thought where the absolutely expectant treatment of fever is practised. As a rule antipyresis is resorted to, but only in extreme cases. I have consulted the statistics of typhoid fever from a large number of sources, and I find that in institutions where this modified expectant treatment is used the mortality averages 15 per cent. In this hospital (Prince Alfred) where the same treatment obtains, the death rate for the past three years has been at the rate of 17 per cent. Of this mortality between 5 and 6 per cent. die from hæmorrhage and perforation—the accidents, as I may call them, of the fever; while the remaining 10 per cent. may be attributed, more or less correctly, to the effects of the pyrexia. But where systematic antipyresis has been resorted to the mortality has averaged only 8 per cent. I am perfectly well aware that epidemics of typhoid vary in severity at different times and in different places; and in some favoured localities expectant has given as good if not better results than systematic treatment in others less favoured at the same time. It is no fair criterion of any treatment to consider its results in one single epidemic or in one single place. For the conditions of different epidemics are never the same, and the results of any treatment may seem to be either more or less favourable than they should be. But I think we eliminate this error by comparing the average mortality of many places where the treatment is in vogue with that of an equal number of centres where the expectant method is used. By proceeding in this way, I have found, as I have already told you, that a diminution in mortality of 7 to 8 per cent. has been brought about by the use of systematic antipyresis. On analysing the mortality we find that of the whole 8 per cent. some 5 or 6 per cent. die from hæmorrhage and perforation, the causes which antipyresis admittedly cannot

affect; so that the saving as we should have expected has been in those causes more directly due to the effects of the pyrexia. These results speak for themselves. Of course, in such a brief paper, I have been unable to do more than indicate the results of the treatment, but I refer those of you who should care to look up more extended statistics on the subject to the *London Medical Record*, of December, 1886—a copy of which may be seen in the Royal Society's rooms—and in which extensive statistics of typhoid fever, both under expectant and antipyretic treatment, in the various German hospitals and in the German army have been recorded by Senator, Goldammer, and others. Other figures may be seen in the *Australasian Medical Gazette*, for July of this year, the Croonian Lectures for 1880, and the Classical Works of Brand, Jürgensen, and Liebermeister.

In other febrile disorders, too, antipyretic treatment has proved successful, though hitherto typhoid fever has given most extensive material for statistics. It may be expected that the success of the treatment will be especially great in those diseases in which the danger proceeds chiefly from the pyrexia and its consequences, and that the more the danger depends on local lesions the less will it be available. In typhus, for instance, though hitherto it has not been used to any great extent, it gives promise of still greater success than in typhoid; while in acute croupous-pneumonia, in which the local lesion looms more largely even than in enteric, the success will not be so great.

And now, gentlemen, to conclude, I trust I have shown that, if antipyretic treatment is to be of any value it must be systematic. I appeal to the favourable results which have been obtained, not in a few instances only, by a few crackbrained enthusiasts, whose wish was father to their results, but invariably where the system has been given a fair trial. No amount of *a priori* theoretical considerations, and no amount of labour and trouble should deter us from any method of treating disease which results in such an immense saving of mortality. I do not for one moment suppose that the matter has reached finality. It has certainly justified its trial, but I have no doubt that extended clinical experience will result in its greater efficiency and in its greater pleasantness to the patient. In its further development I place my hopes in that modification, first suggested by Liebermeister, of Tübingen, in which it is sought not so much to suppress the exacerbations as to strengthen and prolong the remissions of the fever.

I thank you for the kind attention with which you have listened to my paper, which, if it has done nothing else, will have served to promote useful discussion on a most important question in general therapeutics.

PECULIAR POST-MORTEM APPEARANCES IN A CASE OF POISONING BY ARSENIC.

READ BEFORE THE N. S. WALES BRANCH B.M.A.

By F. MILFORD, M.D.

THE usual changes caused by the presence of arsenic in fatal doses are generally found in the stomach and bowels. If death be caused by repeated small doses, frequently administered, not only the stomach but the whole of the small intestines are usually red and inflamed, the entire mucous surface having the appearance of red velvet. I wish to bring under your notice the case of a man, named Robert Phelps, whose dead body presented some peculiar appearances not usually characteristic of death from this poison.

On October 31st last the man's body was found seated on the closet at the rear of 184 Elizabeth street, at six o'clock in the morning—where he had wandered from the street—his extremities were cold and he was supposed to be dead about two hours by the man who found and the policeman who took charge of the remains and conveyed them to the South Sydney Morgue. I was requested by the City Coroner to examine the body, which I did about seven o'clock of the evening of that day—or about fourteen hours after death.

The body was that of a man aged about 33 years, robust, muscular, and well nourished, and had probably weighed about ten stone.

Rigor mortis was present, and cutis anserina was showing on the anterior aspect of both thighs. The only injuries to the skin were three scratches on the gluteal region.

The pupils were dilated, the eyelids open, the mouth open. Upon opening the cranium I found serous effusion under the arachnoid on upper surface of both hemispheres, and about two ounces of bloody serum, or probably cerebro-spinal fluid, effused at the base of the brain. Punctæ cruentæ were well marked on making sections of the cerebrum. On opening the thorax I found the lungs collapsed, occupying about one-sixth part of the cavity of the chest, lying against its posterior surface. With the exception of the collapse they were in structure perfectly healthy.

On examination of the heart there was seen to be atheromatous deposit on the aortic valves, which interfered with their perfect closure, and so prevented them completely doing their duty; the left ventricle was much hypertrophied.

The right auricle and ventricle were full of fluid blood—the left auricle and ventricle empty.

The heart weighed eleven-and-a-quarter ounces.

The apex of the heart was pushed up to the level of the fourth rib by the distended stomach; the axis of the heart was on the same plane with the fourth rib.

I next opened the abdomen and inspected its contents.

I found the liver to be of normal size and shape, and on section internally healthy.

The stomach was seen to be enormously distended, pressing upwards the diaphragm and causing the apex of the heart to be thrown upwards. It occupied the left hypochondriac, the epigastric, a portion of the umbilical and right hypochondriac regions. I tied the viscus at both extremities and removed it from the body. I then weighed it and found that it, together with its contents, weighed forty-three ounces avoirdupois.

The contents consisted of a reddish fluid, principally water, possibly coloured with wine. There was also some three or four ounces of meat semi-digested and the same quantity of potatoes. There was also about a tablespoonful of a heavy greyish paste—which turned out upon analysis to be 280 grains of "Rough on Rats."

About a quarter of the surface of the mucous membrane of the stomach near its pyloric orifice presented a bright scarlet colour; the remainder was normal.

The duodenum on its internal aspect presented a similar appearance to the congested portion of the mucous membrane of the stomach, but the colour was not nearly so intense. The gall and urinary bladders were empty. There was nothing else remarkable about the remainder of the abdominal viscera. There was no departure from the normal standard in kidneys, liver or spleen.

You will then see the only abnormal appearances about the viscera of thorax and abdomen were:—

In the heart.—1st. Old valvular disease of the aorta. 2nd. Hypertrophy of left ventricle. 3rd. Contents of right side of heart copious; of left empty, resembling the appearance of death from asphyxia.

In the lungs.—Collapse.

In the stomach.—Congestion of mucous membrane of pyloric end.

In the duodenum.—Similar appearance.

The usual aspect of the mucous membrane of the stomach of a person who has died from poisoning by arsenic is red and congested, the patient usually vomiting and purging previous to his decease, but there are generally no other distinctive marks by which we may surmise death has resulted from the administration of this poison.

T. Lauder Brunton, 1885 edition of his text book on "Pharmacology, Therapeutics and Materia

Medica," page 292, states that arsenic has the power of paralysing the ends of the vaso-motor nerves.

The same authority states the action of the poison influences the motor ganglia, and is shown by increased rapidity and contraction of the heart.

At page 641 he says "in some cases of poisoning are symptoms of gastro-intestinal irritation, the nervous system being affected, and the patient presents the symptoms of coma very much resembling opium-poisoning."

In this case it was shown by the analysis of the contents of the stomach that more than 200 grains of arsenic were present in the stomach; the patient had not vomited, for the stomach contained so large a quantity of fluid, but whether defecation had taken place I could not say.

It seems to me that the influence of the drug was exercised principally on the pneumo-gastric nerve and caused paralysis of the parts supplied by it commencing at the stomach and extending to the œsophagus, the lungs, heart and larynx.

I have never seen this peculiar appearance of collapse of the lungs in any of the many cases of poisoning by arsenic which I have examined *post-mortem* before, nor have I seen it mentioned in any writers on the subject. I think, therefore, I need not apologize in bringing the subject under your notice.

TREATMENT OF DIPHTHERIA AS ADOPTED IN THE GEELONG HOSPITAL.

REPORTED BY DR. A. W. MARWOOD, RESIDENT SURGEON.

TWENTY cases of well-marked diphtheria were admitted into the wards of the Geelong Hospital during the past three months, with the result that seventeen were discharged, and three died; two of these died in a few hours, being almost moribund on admission. Seven members of one family were admitted, three of the same family having died before they could be brought to the hospital. The treatment adopted here consists of the following, viz. :—

R.—Acid Salicyl.	...	3ss.
Glycerin	...	3ij.
Aq. Calcis	...	3viij.

To be used as a spray every 8 or 4 hours.

R.—Acid Carbol.	...	Min. viij.
Liq. ferri persulph....	3ij ss.	
Glycerin	...	3i.

Paint affected parts every 6 hours, and internally Tr. ferri perchlor. and Potas. Chlor.

Some of the cases so treated were almost hopeless, but, after using the spray, showed signs of improvement. In most of the cases the membrane had disappeared from the eighth to the eleventh day, I then use a solution of Argent. nitr. which quickly reduces the congestion and tumefaction of the affected parts.

The temperature, with the exception of the fatal cases, was seldom above 100°. Albuminuria was a common symptom in the early stages, and epistaxis and a discharge of bloody mucus from the nose was also observed in several cases, showing that the disease had invaded the nasal passages.

In conclusion, I think the above treatment to be very satisfactory, and one worthy of further trial.

Geelong, Victoria, Jan. 2, 1890.

PROCEEDINGS OF SOCIETIES.

NEW SOUTH WALES BRANCH OF THE BRITISH MEDICAL ASSOCIATION.

THE 88th meeting of the Branch was held in the Royal Society's Room, Sydney, on Friday, 6th December, at 8.15 o'clock. Present: The President (Dr. Fiaschi), Drs. Foreman, Crago, Worrall, Hankins, Milford, Quaife, G. A. Marshall, Wm. Chisholm, Bowker, Fisher, Rennie, Breneman, de Lambert, Hodgson, Scott-Skirving, Parker, Brady, Williams, Shewen and West.

The minutes of the previous meeting were read and confirmed.

DR. FOREMAN read some notes on a case of "Extra-uterine pregnancy with Rupture of the Tube," and exhibited a specimen.

DR. WORRALL said, assuming that Dr. Foreman's description of the case was correct, it was almost unique. Primary rupture of the tube very nearly invariably ends in the death of the patient, as there is nothing to stop the hæmorrhage. Dr. Foreman has not made it quite clear as to whether he was able to trace out the broad ligament. This case should be recorded as being one of more than interest to the specialist.

MR. G. T. HANKINS said it would have been better if Dr. Foreman had enlarged upon the subject of extra-uterine foetations for the benefit of those gentlemen who were not gynæcologists. There is one question which he (Mr. Hankins) would like to ask—that is, whether the placenta should be removed? Dr. Tait says it should be allowed to remain so that it can be absorbed.

DR. MILFORD said in recording cases which occurred in the early history of the colony some 80 years ago a case of a patient suffering from extra-uterine foetation is mentioned, in which some time after several portions of the foetus were passed per rectum, etc., and ultimately the patient recovered.

DR. FOREMAN, in reply, said that Dr. Worrall must give him credit for knowing the broad ligament when he saw it. The rupture had taken place through the small opening. He (Dr. Foreman) quite agreed with Dr. Worrall that the usual result of primary rupture was death.

DR. BRADY exhibited a large number of instruments used in the operative treatment of diseases of the nose and throat, and explained their uses.

DR. MILFORD read some notes on an example of the pathological effects of arsenic poisoning.

DR. CRAGO said he had made a *post-mortem* on a man who had died from taking "Rough on Rats," and in this case what struck him was the intensely red colouring of the mucous membrane, but there was no collapse of the lung.

DR. KENNIE said that in the case mentioned by Dr. Milford there was not that generally diffused appearance as if the poison had been absorbed. Perhaps the great distension of the stomach had something to do with the cause of death.

DR. MILFORD, in reply, said he thought that the large amount of fluid in the stomach pressing up the heart might possibly have been a factor in the cause of death. The collapse of the lung in this case was unique.

DR. BOWKER read some notes on a case of "Facial Carbuncle."

DR. MILFORD said he had had three cases of facial carbuncle—two recovered and one died. All three were very painful cases and occurred in ladies, commencing in the cheek and extending through the mucous membrane. Immediately the cases were diagnosed they were treated with the spray, and the two that recovered only lasted about four or five days. In the third case mortification of the eye set in and the patient died after about three weeks.

DR. FIASCHI said that this case appeared to him to be anything but facial carbuncle. From the description it appeared to be more like a disease little known in this colony, namely, charbon. With regard to the treatment the carbolic spray should have been started at once, and the disease would have, no doubt, been more limited.

MR. HANKINS said that the case mentioned appeared to be more like malignant pustule. There is no doubt in cases such as this the carbolic spray goes far to stop the growth.

DR. BOWKER, in reply, said that there was no history in this case to assist in diagnosing. It did not appear to be a case of farcy, as there were no buds and no discharge from the nose as is usual in such cases. With regard to chronic pyemia following carbuncle he (Dr. Bowker) could not say that that was the case. As to the carbolic spray no doubt it would have been better to have used it earlier. The only regret he (Dr. Bowker) had about the case was that he used the knife at all, as it was clearly in evidence that it caused some mischief.

DR. HODGSON moved "That a committee be appointed to explain to newly-arrived medical men who intend practising in New South Wales the laws and ethics regulating medical conduct in this colony." 2. "That such committee seek the assistance and co-operation of any delegates commissioned for the same object by the sister medical assembly in Sydney."

DR. CRAGO pointed out that the Royal Society by its rules could not join in this movement.

DR. SCOT-SKIRVING then moved as an amendment "That as each newly-arrived medical man presents his diplomas for registration before the Medical Board a copy of the agreement between medical men and the friendly societies be placed in his hands, and he be asked to abide by it as far as the circumstances of the locality in which he settles will admit."

The amendment was carried.

MEDICAL SOCIETY OF QUEENSLAND,

GENERAL Meeting, held on August 13 at 8.30 p.m., in the School of Arts, Brisbane. Present: Drs. Thomson, Tilston, Little, Quinell, Connolly, Gibson, Hare, Mullen, Hill, W. S. Byrne and Love. Visitors: Drs. Jefferis Turner and Kelleher.

The minutes of last meeting were read and confirmed. Upon the motion of the President it was decided to send a letter of condolence to Dr. Clowes expressing the sympathy of members with him in his recent bereavement.

The PRESIDENT directed the attention of members to an attack made upon the local medical profession of Queensland by the retiring President of the Royal Society of Queensland in his presidential address.

After discussing the matter the meeting empowered the Secretary to write to the Royal Society expressing the surprise of the Society at the attack and correcting the misstatements in the speech.

The following gentlemen were then nominated for members of the Society:—Thos. Lane Bancroft, M.B. Edin. Ann-street; Wm. Kelleher, M.B. (R.U.I.), Chester-street; Alfred Jefferis Turner, M.D. London, M.R.C.S.

The SECRETARY was instructed to convene a special meeting for Tuesday, 27th, to consider the amended rules.

A discussion followed upon Dr. Hare's paper on "The Effect of the Cold Bath Treatment on Typhoid Mortality," which was read at last meeting. Drs. Thomson, Little, Tilston, Byrne, Gibson, Hill, Love and Hare joined in the discussion.

A vote of thanks was passed to Dr. Hare for his excellent paper.

It was resolved that the annual dinner be held shortly, in order that the Society might entertain Sir William Macgregor, M.D., Governor of New Guinea, who was then in town. Drs. Thomson, W. S. Byrne and Love were appointed a Dinner Committee to arrange date and details.

GENERAL Meeting, held October 8 at 8.30 p.m. in the School of Arts. Present: Drs. Thomson, K. I. O'Doherty, Tilston, E. O'Doherty, Hare, P. Bancroft, Little, Booth, Hill, Mullen and Love.

The minutes of last meeting were read and confirmed.

The SECRETARY shewed microscopical preparation of microsporion furfur stained with osmic acid.

DR. TILSTON shewed heart shewing a perforating ulcer of the aorta.

DR. K. I. O'DOHERTY also shewed an aorta with a perforating ulcer above the valves without any evidence of atheroma or saccular dilatation and read notes of the case.

Upon the motion of the President the Secretary was instructed to write to Dr. Lockhart Gibson, assuring him of the sympathy of the Society with him in his illness.

DR. LOVE then read a short paper on "Antifebrin," which was discussed by the members present.

GENERAL MEETING held November 12, in School of Arts. Present: Drs. Thomson, Little, W. S. Byrne, Clowes, Quinell, Booth, Shout, Tilston and Love.

The minutes of last meeting were read and confirmed. A letter to Dr. Lockhart Gibson assuring him of the sympathy of the members in his illness, and Mrs. Gibson's reply were read.

The PRESIDENT pointed out that a large proportion of the subscriptions for the year was still unpaid, and intimated that at the next meeting he would propose a

motion to the effect that no member should be eligible to vote at an annual meeting whose subscription was in arrears on that date.

DR. LOVE showed a patient with a loose cartilage in the knee joint, and a photograph of an extreme case of osteo-arthritis in a girl aged ten.

A general discussion then took place on the present state of health of the city, in which stress was laid by most speakers on the number of cases of Dysentery, Pneumonia, R  theln, &c.

The Secretary was instructed to order a press for keeping the books and other effects of the society in.

ANNUAL MEETING.

The third Annual Meeting was held on Tuesday, December 10, at 8.30. p.m., in the School of Arts, Brisbane. Present: Drs. Thomson (President), Shout, Taylor, E. H. Byrne, P. Bancroft, Clowes, Lyons, Quinell, Booth, Tilston (Treasurer), W. S. Byrne (Vice-president), Little (Councillor), K. I. O'Doherty and Love (Secretary.) Visitor: Dr. Hoggan.

The minutes of last meeting were read and confirmed. On the motion of the President it was decided to send a letter of condolence to the widow of the late Dr. Jas. Campbell.

On the motion of the Secretary, seconded by Dr. Clowes, it was decided to transfer the annual meeting from December to January, to allow of the more easy adjustment of accounts.

The SECRETARY (Dr. Wilton Love), then read his report for the year, which was as follows:

"Mr. President and Gentlemen,—For the third time I have the pleasure and satisfaction of laying before you the history of the doings of our society for the year, and I think that you will all agree with me in congratulating ourselves upon the continued prosperity and usefulness of our association. There is not now the same fear which existed in the earlier days of the society, that this attempt would be short lived like its two predecessors. On the contrary, there is a conviction growing upon those who know the working of the society best, that its members really value their privileges, and that those upon whom office has devolved are fully alive to the honour conferred upon them.

This has not been accomplished without much work and trouble, for there has been a good deal of inertia to be overcome which has obstructed progress in many ways, some members are often unwilling to take the trouble of writing papers, others are too lazy to attend meetings, while others again forget to pay their subscription till the last moment, all of whom would be sorry to hear that the Society had ceased to exist, but all of whom are alike forgetful that it is only by individual effort that each member can do his duty to the Society, and so make it thoroughly successful. I suppose it is only natural that I should indulge in an annual grumble, for it is upon my shoulders that this extra weight of unnecessary trouble falls, yet I have little doubt that those for whom it is intended chiefly are not present to receive it. To those whose time has been freely given and whose efforts have contributed to our progress, the hearty thanks of the society are due.

At the beginning of 1889 our number was 46. Now it is 55, inclusive of four Honorary Members. Six new members have been elected during the year, and four gentlemen have had conferred upon them the distinction of Honorary Membership, viz., Drs. K. I. O'Doherty, Cannan, Bell, and Margetts, all pioneers of the profession in Queensland, men who have borne the heat and burden of the day, and who are happily still with us to link the past with the present. During the stay

of Dr. Germont and Mr. Loir, Pasteur's representatives, in Brisbane, the Society elected them honorary members. We have lost two of our number during the year, one, Dr. Hill, has left us for Tasmania, the other for that bourne from which no traveller returns, I refer to the late Dr. Campbell of Ann-street. Since last December 11 general meetings, 11 meetings of council and one special general meeting have been held. One general meeting lapsed owing to want of a quorum. The special meeting was held on May 22 to consider a draft Medical Bill, which had been prepared at considerable trouble by Dr. Owens.

Papers have been read on the following subjects:—

(1.) Uses of electricity in certain forms of uterine disease. Dr. W. S. Byrne.

(2.) Treatment of Hyperpyrexia in sunstroke by the cold bath. Dr. Forbes.

(3.) Supports of the uterus in health or disease. Dr. Edgelow.

(4.) Cleft palate. Dr. Gibson.

(5.) Case of typhoid perforation, abscess, formation, recovery. Dr. Dunlop.

(6.) Case of tetanus. Dr. Thomson.

(7.) Effect of cold bath treatment on the mortality in typhoid. Dr. Hare.

(8.) Notes of Perforating Ulcer of Aorta. Dr. K. I. O'Doherty.

(9.) Notes on Antifebrin. Dr. Love.

This list will not bear very favourable comparison with last year's, either in the number of papers read, or in the amount of work involved with one or two notable exceptions. In the coming year this will be otherwise, I trust, and I should be glad if members would volunteer contributions instead of waiting to be importuned into writing them.

Numerous interesting pathological specimens and cases have been exhibited and, unlike the papers, they have been more numerous than last year.

Messrs. Elliott Bros. have from time to time sent new instruments and new preparations to the meetings, and for this the Society wished to tender to them its thanks. Messrs. Burroughs, Wellcome and Co., through their Melbourne representative, Mr. Shepperson, sent a parcel of samples of their improvements in pharmacy to be distributed among the members.

The average attendance of members at the general meetings has been 18.4 and at council meetings 5.6.

The third annual dinner was held in the Masonic Hall on August 24—a date rather earlier than usual owing to the presence in town of Sir William Macgregor, M.D., Governor of New Guinea, who was the guest of the President on the occasion. 23 gentlemen sat down to an excellent dinner, and a very pleasant evening was spent.

Early in the year the question of registration of nurses came before the notice of the society, and it was decided to ask Mr. Watkins, chemist, of Queen-street, to establish a register where nurses could leave their addresses, qualifications and dates of engagements. The scheme was well advertised in the daily papers, and the arrangement has been of considerable value to medical men and patients requiring sick nurses at a short notice. To make the plan work well every member who requires a nurse should apply to this register first, and so compel the nurses to leave accurate addresses and information as to whether they are engaged or not.

The transactions of the society have appeared from time to time in the columns of the *Australasian Medical Gazette*, which has thus done good service in bringing the proceedings under the notice of members who live at a distance and cannot attend the meetings regu-

larly, and also in bringing us more into touch with the profession in the other colonies.

The by-laws of the society have been subjected to revision, and in their revised form will be presented to you to-night for ratification. They will then be printed and each member provided with a copy.

We are still in our old quarters in this room, though an effort was made early in the year to obtain more commodious premises. After much trouble we met in the Divinity Hall in Ann-street, but our tenure of it was shortlived, as we only met there once, the trustees objecting to members smoking, and as the society would not submit to the vexatious restrictions imposed we returned to our old quarters.

At last annual meeting the Hon. Sec. was relieved of the treasurer's duties, and a special office of treasurer was created in connection with the post of Curator of Library and Museum. This has lightened the work of the Secretary to some extent. Dr. Clowes and Dr. Hardie have kindly acted as Auditors.

The Treasurer will inform you as to the financial position of the society which remains very good, as over fifty pounds are available for any purpose to which the members may see fit to devote it. We have at length procured a press in which the future library will be deposited, and if the books with which we hope to fill its shelves be circulated among the members, I have no doubt that the librarian of the School of Arts would for a small remuneration keep the keys and distribute the books as asked for. I have obtained quotations for some standard works—S. Hutchison's "Illustrations of Clinical Surgery," Hebra's "Atlas," Sydenham Societies Publication, &c., and I hope it will not be long before we shall have a useful collection of such works.

The society is indebted to the retiring President Dr. Thomson, not only for the able manner in which he has discharged the duties of the chair, but also for the courteous hospitality which the members of council have met with at his hands, the various council meetings throughout the year having been held at his private residence. I have also to thank the other office-bearers for the ready co-operation and indulgence which they have shown towards myself.

In conclusion I have only to urge the members to make their interests in the society a little more vital, and to impress upon them the need of individual effort. If this be conceded there is little doubt that our society will continue to grow more and more prosperous and useful, and will become a powerful factor for good among the profession. With the sincere wish Mr. President and Gentlemen I conclude my report for the year 1889 in the words of Juvenal:—

'Macte tua virtute—Sic itur ad astra.'

A vote of thanks to the Hon. Sec. (Dr. Wilton Love) was proposed by Dr. Little and seconded by Dr. E. H. Byrne, and the report was then adopted.

DR. TAYLOR took exception to some remarks of the Hon. Sec., and thought that they ought to have come from the Chair.

The SECRETARY explained that the unnecessary trouble complained of affected him much more directly than the President, and thought that it was only his duty to call the attention of members to it.

On the motion of the Secretary the annual meeting was adjourned till the following month to allow of the Treasurer's report, which was not complete, being presented.

DR. K. I. O'DOHERTY expressed a wish that being now resident in Brisbane he should join the ranks of the subscribing members. After discussion, and upon Dr. O'Doherty's expressed wish, his name was announced for ballot at the next meeting.

The election of office-bearers for 1890 then took place:—President, W. S. Byrne, M.B.; Vice-president, W. F. Taylor, M.D., M.L.C.; Hon. Sec., Wilton Love, M.B.; Hon. Treasurer, P. Bancroft, M.B.; Council, Jno. Thomson, M.B., W. Lyons, M.R.C.S., L.R.C.P., and E. M. Owens, M.R.C.S., L.S.A.; Auditors, J. S. Clowes, M.R.C.S. and David Hardie, M.D.; Trustees, Jos. Bancroft, M.D. and J. J. Mullen, L.K.Q.C.P.I.

DR. TAYLOR proposed, and Dr. Little seconded, "That the rules and proposed amendments be printed at a cost not exceeding £5 and distributed among the members for discussion at a special general meeting."

DR. LOVE proposed as an amendment, and Dr. Booth seconded, "That the rules as revised by Revision Committee be discussed at the adjourned annual meeting in January." Amendment carried.

The retiring PRESIDENT, Dr. John Thomson, then read the following

ANNUAL ADDRESS.

It appears to be an unalterable law of all societies that the annual president should deliver an annual address, introductory, valedictory, but still presidential. Would that I could break this rule, and would that you might help me. But it seems I must conform to the custom.

In reviewing the labours of our society during the year I unconsciously began to review my own past work, and what struck me most, perhaps, was the very extraordinary strides, strides I find it impossible to keep pace with, which the healing art has made during the last quarter of a century, the time since I began my schooling. The gains have been astonishing, the losses very few. Chloroform was certainly introduced before my day, and you may say it revolutionised the surgeon's art, but nevertheless it killed the surgeon, if by him you mean the *chirurgus*, the handicraftsman, the man of deft fingers. To believe this you must have seen a Syme or a Ferguson operate; they learned their craft in the pre-anæsthetic days, in the terrible times of screaming and groaning, when the patient's agony was of itself enough to unman the operator; time was then all important; every step of the operation and every possible complication or accident had to be provided for. No opportunity then for consultation; no referring to brothers for advice or assistance; the work had to be done and done quickly, it was brilliant work, it was a species of legerdemain. I have seen a limb removed at the hip joint in 22 seconds, but the men who did that work are dead, the race is extinct. Chloroform killed them. But if it destroyed these it has saved countless thousands; thanks to it many operations our fathers never dreamed of are now readily performed.

Abdominal surgery has sprung into existence; it was not taught in Edinburgh twenty years ago; now its results are ceasing to astonish, and I am proud to be able to say that many of our members here can record success in nearly every field of abdominal work.

The next great advance occurred when I was still a student, and if to anæsthetics I have given the first place—and they are entitled to it from their seniority—to Listerism is due, also, an immensity of the success I have already referred to. What Listerism means rhetorically I am not now going to argue. That Listerism was carbolicism is proved to be incorrect; that Listerism is carbolicism may also prove false, but that practically it is cleanliness; absolutely scientific, no one will deny.

And yet this very cleanliness is seldom if ever understood by any but the operating surgeon or those trained like him. Educated people don't understand it, many trained nurses can't grasp it.

It seems mysterious how the old operators were so successful; no efforts were made to secure this scientific cleanliness (I carefully avoid the term aseptic). As a dresser I remember the sponges were not the objects of any special care or attention, nor were the instruments, nor the ligatures, nor the dressings, nor anything else. And yet to this very science of purity, the result of Lister's research, surgery is deeply indebted, a debt, however, she is rapidly reducing by the brilliancy of her achievements.

Among the other losses of the century's quarter is the art of bloodletting—phlebotomy. How many of you have opened a vein? How many have seen the operation performed. Yes, it is a lost art. To see one of the old practitioners whip out his lancet and draw blood, as he termed it, looked almost like a piece of jugglery, it was done so quickly and yet so carefully. He would have dubbed himself a sorry leech who either soiled the garments or stained the bed-clothes with the red stream. I have often wondered whether it has been wise to let the art die. The blood may be the life, but taking away a little of that life when it was superfluous was attended with astonishing benefit, and those among you who have had experience in certain forms of puerperal eclampsia, will surely agree with me, the result is immediate, it is astonishing. In olden days grateful patients almost invariably presented their benefactors with silver lancet cases; it was the recognised reward; successful practitioners had drawers full. But with the loss of the art the practice of recognition fell into disuse, and now our cabinets contain no silver cases.

Among the other aids the surgeon now enjoys must be mentioned cocaine. It has simplified the labours of the oculist and the laryngologist, and work which in the past was irksome to the operator and trying to the patient is now comparatively easy.

Then, again, electricity is a trade in the hands of the surgeon; and the last two or three years have seen advances not only in the form of apparatus but in the mode of application, and those forms and modes in their very latest development are in constant use by our brethren here who have from time to time given us records of their work—of their successes and their failures; very different from the days when I was at school, and when electro-therapeutics consisted of giving a so-called shock. A wretched box contained revolving apparatus; the patient was told to hold on; the operator ground the handle; the former was convulsed; the latter said: "Ah! that's good! that's putting life into you!" Fancy Apostoli or de Watteville at this work!

Then, again, methods of physical examination have almost outgrown the purse or opportunities of the general practitioner. Twenty-five years ago the observer was fully equipped if he possessed a stethoscope—which he carefully carried in his hat, and which did more to wear out that article than did the head which it covered—a test tube or two and a spirit-lamp, and, possibly, a cheap French microscope. When I was a clerk in the clinical wards no one owned a thermometer, not even Bennett—the grandest teacher of his time. The tongue and the pulse were the polar-star to steer by, a thermometer-chart was unheard of, and the now common expression, "so-and-so has a temperature," would then convey no meaning. But in those wards we had no appliances, neither ophthalmoscope, laryngoscope, spirometer, sphygmograph, aspirating needle, weighing machine, electric reaction or anything else; and yet, the men of those days, without such physical aids to diagnosis, but

depending upon keen and careful observation, obtained an almost intuitive acquaintance with disease, and were nearly as assurative as their modern brethren of the scientific school—they were like the shepherd or the fisherman in opposition to the instrument-aided meteorologist in forecasting the weather, and they did good work, and we now profit by their experience.

Probably the advances in pathology have been as great, if not greater, than in any other branch of our art. In my time at Edinburgh we had no philological laboratory—I am not sure that we had even a museum. Professor Henderson never had any specimens on his lecture table, and unfortunately, because he was a quasi-homœopath, and not in touch with his fellows, had no wards or any means for clinical teaching—all we learned of pathology was from a slip of paper at the infirmary gate with the legend thereon: "*Secitio cadaveris hodie*," and at least the bulk of us were satisfied. But all that is altered; the logos of disease is now stirring the energies of observers, and the astonishing revelations of the Bacteriologists are now demonstrating with photographic precision what, to the observers of the past, loomed up only like men as trees walking.—Mark viii., 24.

But, with an advanced acquaintance with disease, progress has also been made in the means of combating it: salicylic acid and salicylates have been added to our *Materia Medica*, and he would now be a bold man who would despise them. The bromides have not had more than about five-and-twenty years' run. Chloral has just barely attained its majority. Apomorphia, pilocarpin and strophanthus have nearly reached puberty, while antifebrin and antipyrin are only cutting their first teeth. What would we do without cascara? or where would we be without iodoform? and yet these are only a few of the thousand and one drugs which have been rushed on the market during the last decade or two. A rush, we must admit. Still they come, but it seems to me their advent is not an unalloyed blessing. Don't think we are conservative in medicine. I take second to none in my extreme liberalism; but I am afraid when I hear of the profession generally, like the Athenians of old, spending their time in nothing else but either to tell or to hear of some new thing, and that thing a drug, I fancy it proves that the older remedies are not reliable, the present ones uncertain, and the whole treatment of disease doubtful, and, without being thought pessimistic, let me venture the opinion that with all our modern advance we are but little better than our grandfathers in dealing with the so-called "slight ailments." And if I am wrong you will correct me; the whist axiom: "When in doubt play a trump," has its counterpart in medicine: "When in doubt give an alternative," and then either mercury or iodide of potassium is prescribed, and, what is remarkable, with often astonishing advantages.

But of all the changes in the administration of drugs during the last quarter of a century none is more effectual than that obtained by the hypodermic needle. The old medicine chest is almost antiquarian, and the essentials of the *materia medica* are carried in the vest pocket. Happy thought! Might not grateful patients be led to donate silver hypodermic cases, as of old they did the lancet boxes?

Having mentioned changes and innovations, let me refer to what I think at least one loss, and that is the disuse of emetics. Swilling out the stomach; washing it as you would a dirty basin, is not fashionable, it savours too much of the vulgar and the rude. But when that organ is at fault it strikes one very forcibly that it is wiser to cleanse it by returning its contents, what ever they may be, up the few inches of gullet rather

than forward them on through the many feet of intestine. And those who have had experience in the past of the abortive treatment of croups and pneumonias by antimony, will wonder why emetics are shunned in the present. It may be that depletion is wholly wrong, and that our fathers were the fools who rushed in where we angels fear to tread; but those who have seen both methods and treatment will believe there was quite as much, perhaps more success, and a great deal more charm in the heroism of the past than in the masterly inactivity maintained by the watchers of the modern school.

The science of hygiene has sprung into existence since my time; then it was not taught, now degrees are given in it. That it is new, I doubt; that it is only revived, I believe; old Moses the law-giver was sound in sanitary science, and had his rules been observed through all the ages, I fancy the world would now be more crowded than it is, and the cities of the earth be over-stocked. And that gives rise to the very delicate question, how far are we being benefited by the lives which an observance of the laws of health is annually saving. The cry of the past was "the survival of the fittest," and they who answered to it were the strong and brave; the weak and puny were trodden under foot in the race and the struggle. Now the cry is the survival "of all;" and if all survive—if the weak grow up and the puny exist; if deformities and debilities and defects, mental, and physical, marry and intermarry—will this be counter-balanced through "the survival of all," of the strong growing stronger, and the brave, braver? I cannot answer. Yet who can predict the possibilities of hygiene, or who realize its vast potentialities? To my mind it is the grandest and the noblest of all our arts, and as it strides on it may yet effectually stamp out many of the diseases which at present well nigh baffle us. Oh that some hygienic Hercules would arise and cleanse and purify this fair city of ours, and free it effectually from what I dread will be its curses—typhoid fever and diphtheria!

Other methods of treating disease other than those regularly taught in infirmary wards have sprung into existence, and the chief of them are the mental and mechanical. In the former are included Hypnotism: treatment by suggestion and the influence of the mind over matter. In the latter we find massage with all its nice distinctive technicalities, and treatment by rest, seclusion, &c.

And a great deal can be said for both. Anyone who has read Binet and Féré's manual, the result of their experiences at the Salpêtrière, must admit the wonders of the philosophy, and all of us are aware of the astonishing influence the mind seems to exercise over those trifling and homely little growths on children's fingers—the common wart. As for massage, although some of its critics declare it is only a vicarious method of exercising the muscles of indolent individuals, and that at best it is but a refined shampooing, those who have watched its effects in suitable cases must have been satisfied with the beneficial results obtained; and even if they do not agree with all that is claimed for the process, they must acknowledge that from it we can obtain valuable help.

And that leads me to observe that the fancied help or the assistance a practitioner obtains from any theory of treatment has too often been the means of wedding him to one scheme, with the inevitable result that his field of usefulness has been narrowed and his ideas have been dwarfed. I take it that the first duty of every member of our art is to his patient, and for the successful discharge of this he must keep himself in touch with modern thought and experiment; but he must do

more, he must gain knowledge by experience, and that experience will so broaden his belief that he will cease to attach himself to any particular sect, but will discover truths in some of the narrowest philosophies, and will admit that all the "pathics" are of service to him. He will use them with wisdom and for the benefit of those under his care, and he will become in the most liberal sense of the term an eclectic, for his scientific training will be strengthened and be balanced by empiricism. He will glean his aids from every source and use them with that wisdom and that judgment which observation and experience can direct. I would that the terms allopath, homœopath, hydropath were forgotten, and that a truer liberalism might bring together those who are faithfully working for one common good.

In referring to some of the medical annals of my term, the loss of the University Bill, I think, is to be regretted. While we, as a society, did not feel inclined to take action because we did not believe the time had yet arrived when a medical school could be founded in Brisbane with any hope of success, still the establishment of a University dealing with other branches of knowledge and of science would have been the keystone of the educational edifice which has been reared here, and of which we Queenslanders are justly proud, for its motto is "No one dares be ignorant."

The affairs of the Central Board of Health deserve a passing notice. Some time ago in the Assembly the Premier attacked the Board and made statements which were certainly rash and were calculated to mislead those who did not happen to possess a knowledge of the truth. That the usefulness of this Board has not been as pronounced as one might have hoped will be admitted. This has arisen from various causes, chief of which are a jealousy on the part of the various local authorities who have seldom or never shewn any desire to co-operate, and the action of a section of the local press, which has in a studied fashion assisted to foster this jealousy by constantly attempting to hold up the Board and all its deliberations to ridicule and contempt. Whether the Premier's threat "to move or remove the Board" may effect a change, time will shew; but I at least believe in the usefulness of the Board.

The Medical Board have been unfortunate. A Bill was drafted by Dr. Owens, but it never entered the Assembly. Had it become law I believe it would have purged our fair land of those leech pariahs which chiefly infest the larger towns and fatten on those unfortunate victims whom they rob and ruin. While I should like to see those advertising scoundrels punished, I think a discretion should be exercised with some of the irregular or unqualified practitioners who are to be occasionally met with. In a thin and scattered population like ours good work has at times been done in bush towns or on new goldfields by men whom the law could punish, but whom justice should protect. Let us be charitable towards them: they seldom worked for gain.

I regret I cannot report any material progress in the establishment of inebriate homes. The necessity for these is universally admitted; and surely a State which derives a large portion of its income from what is known as the Drink Traffic ought to provide some means of rescue for those unfortunates who suffer through the trade.

Now for ourselves. The Secretary's report tells its own tale; the work done has been satisfactory, the attendance good, and the finances are in a satisfactory condition. The members are increasing in number, although death has removed one, and two others have left the colony. I have to thank the council for the assistance I have received from it, and I have to express my regrets that Dr. Hill should have seen fit to leave Brisbane, and

that Dr. Gibson's usefulness both to us and to the community should have been interfered with by his prolonged indisposition. I am sure his speedy recovery is heartily desired by us all. But whatever good this Society has achieved is to a very great degree, if not entirely, due to the enthusiastic energy of our friend and colleague, the Hon. Sec., Mr. Love. What we would have done without him I am sure neither you nor I can tell; you can hardly know the amount of work he has done for the Society. I do; and I feel it my duty, on retiring from the chair, to which you did me the honour to appoint me, and for which honour I now heartily thank you, to record my indebtedness to the Hon. Sec. for the valuable assistance he has rendered me.

A hearty vote of thanks was accorded to Dr. Thomson for his address and to the retiring office-bearers for their services during the year.

PROCEEDINGS OF COLONIAL MEDICAL BOARDS.

The following gentlemen, having presented their diplomas, have been duly registered as legally qualified Medical Practitioners by the respective Boards:—

NEW SOUTH WALES.

O'Neill, William Henry Basil, M.B. & M.S. Univ. Edin., 1889.
Blumenreich, Theodore Meyer, M.B. & M.S. Univ. Edin., 1887.
Howse, Neville Reginald, M.R.C.S. Eng., 1886.
Wilson, Francis, L.R.C.P. Edin., 1878; L.R.C.S. Edin., 1877; Dipl. in State Med. R.C.P., Edin., 1888.
Atcock, Martin Henry, M.D. & M.Ch. Roy. Univ. Irel., 1882.
Clarke, William, L.S.A. Lond., 1886; M.R.C.S. Eng., 1888.
Shiels, Edward Eudallo, L.R.C.P.S. Edin., 1883.
Mathias, William Lloyd, M.R.C.S. Eng., 1888; L.R.C.P. Lond., 1888.
Cheyne, Robert, L.R.C.P. Edin., 1883; L.S.A. Lond., 1881.
For additional Registration:—
Boake, William, L. 1888; L. Mid., 1888; K.Q.C.P. Irel.
Rennie, George Edward, M.D. Lond., 1888.

NEW ZEALAND.

Aynsley, J. H. Murray, M.R.C.S. Eng.; L.R.C.P. Lond. 1889.
Ingils, Herbert McClelland, M.B. & Ch.M. Edin.
Kerr, John, M.B. & Ch.M. Glas., 1888.
Adams, Harry, M.R.C.S.E., L.R.C.P. Lond.

QUEENSLAND.

Griffin, John Henry, L.R.C.S. Irel., 1883; L.A.H. Dub., 1884; L. Mid. K.Q.C.P. Irel., 1886.
Howard, Henry, L.R.C.S. Irel., 1874; L.R.C.P. Ed., 1875.

VICTORIA.

Ghandy, Rastamji Dinshaji, L.S.A. Lond., 1881; L.F.P.S. Glas., 1882.
Duff, John, M.D. C.M. Queen's Univ., Ontario, 1889; M.O.P.S. Ontario, 1889; L. & L. Mid. R.C.P. & R.C.S. Edin., 1889; L.F.P.S. Glas., 1889.
Ellison, John, M.D., Royal Univ. Irel., 1883; C.M. Royal Univ. Irel., 1887.
Gaffney, Charles Burke, L.R.C.S. Irel., 1879; L. & L. Mid. K.Q.C.P. Irel., 1881; F.R.C.S. Irel., 1889.
Little, William Clow, M.D. C.M. Queen's Univ. Ontario, 1889; M.O.P.S. Ontario, 1889; L.R.C.S. Edin., 1889.
Somers, James Louis Edgeworth, L.R.C.S. Irel., 1883; L.A.H. Dub., 1883.

Wanted the following back numbers of the *British Medical Journal* to complete a set:—April 14, 1883; October 6, 1883; June 14, 1884; September 13, 1884; October 3rd, 1885; January 2, 1886; January 16, 1886; May 7, 1887; August 11, 1888.—B. Poulton, 33 North-terrace, Adelaide.

For Sale, Medical Practice, suburban to Adelaide.—£1,500 taken last year, and susceptible of increase. Ample introduction will be given. Principals only dealt with.—Apply, F. H. Faulding & Co., Adelaide.

NOTICE.

The Editor will feel obliged by any gentleman, who wishes to ventilate any subject of professional or public interest, writing an editorial or leading article on it, which if found on perusal to be consonant with the policy of the paper, will be inserted in an early number.

All communications intended for the Editor should be sent to the 'A. M. Gazette' Office, 35 Castle-reagh Street, Sydney.

*** Contributors can have their Papers reprinted and published in Pamphlet form, at Cost Price, if the necessary instructions are given to the Publisher at the same time the contributions are sent in.*

AUSTRALASIAN MEDICAL GAZETTE.

SYDNEY, JANUARY 15, 1890.

EDITORIALS.

MEDICAL LEGISLATION IN SOUTH AUSTRALIA.

THE Act to amend the Medical Act of 1880, which was passed by the legislature of South Australia during the last session of Parliament is a distinct advance, which will do much to prevent fraud and imposition on the people of that colony by persons who, in the future, may attempt to irregularly practise medicine there. Clause three provides that any one who shall *falsely pretend* to be a legally qualified medical practitioner, or *falsely pretend* to have or use any diploma * * * other than that which shall have been *bona fide* granted to him shall, on conviction, forfeit fifty pounds. But it provides that any one who has heretofore practised medicine and surgery continuously in South Australia for five years shall not be liable to any penalty by reason only of his continuing to use the title of "Doctor." This clause was added to the Bill in the Assembly on recommitment, on the motion of Mr. Stirling, to take the place of a somewhat similar one which had been struck out; without it the Bill would have been an abortion, not worth the time expended on it. Clause five directs that no certificate of the cause of death shall be given except by a legally qualified medical practitioner, and it also says that no burial shall take place without such a certificate, or an order for burial by a coroner. It provides, however, that this clause shall not apply to places which are at a distance of more than five miles from the residence of a legally qualified medical practitioner or coroner. This

distance is, we think, much too little; it might safely have been 10 or even 15 miles without hardship to the friends of deceased persons. The provision is, however, a necessary one for the more thinly populated districts. In this clause, as in number three, the interests of quacks of five years' standing are carefully conserved at the expense of the ignorant public. Clause six provides for the removal from the register of the name of any practitioner who shall be convicted of any felony or misdemeanour, or who shall have been deprived of his qualifications by the bodies which granted them. This would appear to apply to future cases only, in which case clause eight would seem to entitle men who prior to the passing of this act have suffered such disabilities, but have been previously registered in South Australia, to claim to be retained or if already removed to be restored to the list of qualified medical practitioners. Clause eight is an all-important one, which provides for the attendance before and examination of witnesses by the Medical Board, for the punishment of such witnesses on giving false evidence, and of any person procuring or attempting to procure registration by means of spurious diplomas, by imprisonment for any term not exceeding three years.

The very gist of the new measure is, however, contained in the schedule which replaces that in the Act of 1880, repealed by clause two. By this schedule the value of a diploma granted by any licensing body, except those recognized in Great Britain, is left to the discretion of the Board. It provides that the holder of such a diploma shall be registered if it, "*in the opinion of the Medical Board,*" is equal to the qualifications entitling the holder to be registered in the United Kingdom. Had such a provision existed in the Act of 1880 the recent incident in which the Medical Board of South Australia was compelled by the Supreme Court of that Colony to register a diploma which it conscientiously believed to be insufficient would not have occurred, and a grave scandal would have been avoided.

Though we think the new Act will be of great service to the public, we think it might have been made more effective had it gone further on the lines recommended in the report of the select committee of the Legislative Council of New South Wales. For instance, had it provided that all medical practitioners who are in active practice should place a notification of the fact, as they do now on the house in which they carry on their calling, and that those who are not registered should add "Unregistered by the Medical Board." This would enable the most stupid person to know at a glance what style of medical man he

applied to for advice. We have never advocated the prevention of the practice of medicine by any one, for this would, we think, create an "army of martyrs" under false pretences, and would excite that maudlin sympathy so rife in these colonies under such circumstances. We strongly press, however, that it should be plain to every man as to whether a medical practitioner is qualified or not. Then if people desire to consult a charlatan or impostor, we certainly do not think it any one's duty to guard such idiots from the effects of their imbecility.

VICARIOUS CHARITY.

It appears that lately the doctors at Broken Hill have been giving dire offence to the many philanthropists residing there, who are so thoroughly charitable when their charity is no expense to themselves. This district, like every other place, is well supplied with those *good* people, who were so pithily described by Sydney Smith when he said they would always be willing to act the "good Samaritan if it were not for the oil and the twopence." It is well that medical men should, from time to time, give a practical proof, that the practice of medicine is a calling followed after a long and expensive training as a means of livelihood, to the amiable but penurious imbeciles who are so willing to prove their charity by demanding the services of a doctor in "a case of sudden death," without that practical and desirable proof of their earnest disinterestedness—the tender of a fee. We republish a letter and editorial note, apparently a satirical skit, which appeared in a recent issue of the *Silver Age*, the newspaper of the Barrier district, which shows that the paper has taken the commonsense view of the situation, which is so often absent from the lay mind:—

THOSE DOCTORS.

(To the Editor of the "*Silver Age*").

SIR,—I see in your report of a sudden death that occurred near the railway station early on Wednesday morning, that a messenger was dispatched for assistance to three medical men in the town, and that neither of them would leave their houses without a fee being paid to them. Now, sir, I beg to ask for what purpose do doctors exist among us if not to render their services at all hours of the day or night at the request of any one of us without any guarantee or emolument whatsoever? It is absurd to consider seriously the so-called risk to health involved in turning out of bed into the cold night wind—the only possible defence which can be brought forward for such an action as you report. What do these men want? To be paid for their services? I say, sir, it is monstrous that such men should be permitted to live with us. Why do not the doctors adopt the example of the rest of us who live in Broken Hill, and work manfully and cheerfully for nothing?

Men who take such precautions as shall ensure their work being remunerated, should be widely known in order that they may be avoided by every honest

WORKING MAN.

[The sentiments embodied in the above letter are admirable. It is perfectly absurd for doctors to expect the ordinary man to pay. It is an immemorial custom to defraud the profession of their fees, and custom must be upheld at any cost—to the doctors. Let our medical men learn of the good Samaritan and be wise. That philanthropist not only dressed the wounds inflicted on the man who had been grievously assaulted, but took him to an inn, paid in advance for board and lodging for him, and even gave a promise to defray further expenses. We can love and respect the memory of that Samaritan, but what utter contempt must we feel for the latter-day doctor, who, after exerting his utmost skill to arrest disease and to save life, descends to the level of a clergyman, a lawyer, or a policeman, and asks for money! It is too utterly absurd. Medical men should have some thought for their patients.—ED. S. A.]

LETTERS TO THE EDITOR.

UNQUALIFIED PRACTITIONERS.

(To the Editor of the A. M. Gazette).

SIR,—I shall esteem it a favor if you will, through your columns, inform me on a point of importance to the profession. Can an unregistered (and therefore probably unqualified) man, styling himself "Doctor," and in a court swearing himself to be a "duly qualified medical practitioner," legally claim and recover in court fees for medical attendance? Does he not, by misrepresenting himself to the public, forfeit his claim to remuneration? I am writing on account of a patient of mine whom such a man as the above has got into his power, and has threatened to "sell up" if he prefers to engage me any more. I shall be much obliged if you will give me your opinion; and remain, yours faithfully,

GENERAL PRACTITIONER.

[Any person, whether registered or not, can, in New South Wales, recover fees for attendance as a medical practitioner, on suing for "work and labour done." The only way in which the victim of such a man can hope to escape from the consequences of his folly would be by letting the case go to the court, and then by means of cross-examining the plaintiff when in the witness-box, making him state definitely what he means when he swears he is "a duly qualified medical practitioner," and also give his reasons for not having been registered by the Medical Board. Under such circumstances, he would probably fatally expose himself or render himself liable to prosecution for perjury. As to the promises of coercion made, the question *might* arise as to whether they would render him liable to a similar peril for obtaining money by means of threats.

The case as related by our correspondent is but another added to the already numerous examples, showing how grossly the Government is neglecting its functions when it fails to give effect to the recommendations of the Select Committee of the Legislative Council, as to the necessity for the passage of such a Medical Bill as would protect the public from fraud and oppression by ignorant pretenders.—ED. A.M.G.]

DISEASES MET WITH AT BROKEN HILL.

(To the Editor of the A. M. Gazette.)

SIR,—During a residence of three months, as House-Surgeon to the Broken Hill Hospital, I was greatly impressed by the rapidity with which wounds heal after injuries and surgical operations. I have been connected a good deal with Colonial Hospitals, but never noticed this so much as at Broken Hill. They have a nice, well-ventilated institution with all the latest improvements, but this does not sufficiently account for such quick results in surgical cases. Pus is seldom seen, the wound either healing at once by the first intention, or granulating with the slightest possible amount of suppuration. Some cases that came under my notice were so severe that death or amputation would have been the result in a London Hospital. I can recall a few of the cases. One was that of a miner whose skull had been severely fractured over the frontal bone to one side of the longitudinal sinus. In this case the superficial wound united too soon, and an opening had to be made to allow of the exit of a little matter, caused through the splintered condition of the bone. The man, however, had few bad symptoms, and was able to leave the hospital in a short time—considering the fact that several pieces of dead bone had been removed—I have never before, except in children and insane people, noticed a similar case of compound fracture of the skull progress so well.

Another case was that of a man with intestinal obstruction. The operation of laparotomy was performed after other means had failed. The air was neither rendered aseptic by the spray, nor were any extraordinary measures taken to produce an antiseptic condition of the parts around. The obstruction was broken down after some searching, and the edges of the wound brought together with sutures, after which salicylic wool was applied. It was not again touched for a week, during which time no rise of temperature whatever nor any bad symptoms took place. At the end of the week the wound had perfectly healed by the first intention, and in 18 days the man was able to leave the hospital. I could mention other cases of severe lacerations after blasting, but don't wish to take up too much space. I put the rapid healing of these wounds down to the extreme dryness and purity of the air.

Among the most common diseases about Broken Hill is lead-poisoning, which usually does not go beyond the stage of severe abdominal tenderness with constipation, and is soon relieved by treatment. A form of eczema is also common, but soon yields to arsenic and lead lotion. The two most intractable affections are dysentery and granular lids, which often baffle all treatment. Insanity is very common, the number of cases being out of proportion to the population, and I am told by outside medical men that they meet with a great deal of hysteria. Typhoid was very bad last summer, but thanks to better sanitary arrangements is now very much less, however, I may speak about this on a future occasion.

The elevation of Broken Hill—which is 1,100 feet—gives to it cool nights, and far from being the "unhealthy place" that Melbourne and Sydney people call it, is at least entitled to the name of a "Surgical Sanatorium."

I am, etc.,

JOHN ERNEST MOFFITT,
Resident Surgeon.

Creswick Hospital, Victoria,
21st December, 1889.

UNUSUAL CASE OF PLACENTA PRÆVIA.

(To the Editor of A.M. Gazette.)

SIR,—I believe the following to be an unusual *finale* to a case of placenta prævia which you might find room to insert :—

Mrs. B—, aged 30 years (sixth pregnancy), called me in on September 16, being much alarmed at bleeding from the passages; stated she was five months gone; says the same occurred last pregnancy (about two years ago), when Dr. Tilley, lately of Warwick, attended her and told her "the after-birth was in the way." Labour came on spontaneously at seven months, and she was delivered of a female child before the doctor's arrival. He expressed great astonishment at this, and on examining the after-birth found a rent in it through which the child's head had forced its way to all appearances. (I remember that Dr. Tilley told me about a case of the sort which I presume was this.) I examined and could not feel any evidences of the child per vaginam, only the feeling of a soft mass of some size which I took to be the placenta.

On October 19 (six months) the same occurred again. Examination gave same result with no enlargement of the os.

November 10 (seven months), 11 p.m.—Labour pains commenced.

November 11, 3 a.m.—Called in. On examination head felt with small portion of anterior lip of cervix not yet fully dilated; not a sign of placenta; no bleeding, nor has there been any to speak of.

3.15 a.m.—Membranes ruptured, and at the next pain the child was expelled. As I received the cranium with the palm of my hand I felt the sensation as of the rending of a considerable mass of tissue. The head passed on, and as it passed over my hand I could feel no features on account of the interposition of a large fleshy mass. I thought it was a monstrosity of some sort, but on complete expulsion I looked at it and found all normal except for a caul enveloping the head and shoulders. I had considerable difficulty in making the child breathe on account of mucus filling the mouth and nose, and for a short time forgot all about the fleshy mass I had felt. Then I remembered it, and feeling under the bed-clothes found a piece of placenta about the size of the palm of my hand. It was very much disintegrated and full of old blood clots. When the rest of the placenta came away, which it did with a little expression, the place where the loose piece had come from was plainly seen, giving, if I may use the term, the appearance of a piece bitten out of a sandwich. A few clots came away; child, female, very strong for a seven months' foetus; has every appearance of surviving as its predecessor, also a female, did.

Now I suppose this loose piece was the portion of placenta that projected across the internal os, and owing to the expansion of the uterus as pregnancy advanced became detached, causing the bleeding, and was lying valve-like over the passage of exit. When labour came on (the woman's labours have always been rapid) the head was rammed down on to this, and forced it into the vagina. When complete flexion took place the occiput came down and was felt by the finger, and the piece of placenta was pressed between the face and posterior wall of the vagina. When the last expulsive pain came the shoulder of the child drove this piece on and tore it from the rest of the placenta.

I am, sir,

Yours, etc.,

FRANCIS PAIN, M.R.C.S., &c.

Allora, Queensland,
November, 1889.

THE NEW MEDICAL ACT FOR SOUTH AUSTRALIA.*

1. This Act may be cited for all purposes as "The Medical Act Amendment Act, 1889," and, except so far as inconsistent therewith, shall be incorporated and read as one with the Ordinance No. 17 of 1844, and the "Medical Act, 1880."

2. The Schedule to the "Medical Act, 1880," is hereby repealed, and the said Act is hereby amended, and shall be read and construed as if the qualifications mentioned in the Schedule hereto had been inserted in the said Schedule to the said "Medical Act, 1880," in lieu of the qualifications therein set forth.

3. Any person who shall falsely pretend to be a legally qualified medical practitioner, or who shall use any spurious diploma, or falsely pretend to have or use any diploma as physician, doctor of medicine, licentiate of medicine or surgery, bachelor of medicine, or any other name or title other than that to which such person is actually entitled, or other than that which shall have been *bonâ fide* granted to him, shall, on conviction, for every such offence forfeit and pay a sum not exceeding Fifty Pounds: Provided that any person who has heretofore practised medicine or surgery continuously in South Australia for a term of five years shall not be liable to any penalties under this section by reason only of his using, or continuing to use, the title of doctor.

4. The names and qualifications of all legally qualified medical practitioners, together with the dates at which their qualifications may respectively have been obtained, and the dates of registration of such medical practitioners respectively, shall, on registration, and in the month of January in each year, be published by the Medical Board in the *Government Gazette*.

5. (a) No medical certificate of the cause of death shall be issued for the purposes of "The Registration of Births and Deaths Act of 1874" except by a legally qualified medical practitioner:

(b) No burial of any deceased person shall take place without a certificate of the cause of death under the hand of a legally qualified medical practitioner, or an order for burial signed by a coroner of the said province within the meaning of "The Coroner's Act, 1884":

(c) For the purposes of the said Act, all deaths not certified as in the preceding subsection mentioned shall be deemed and considered to be uncertified deaths:

This section shall not apply to any person who has heretofore practised as a surgeon, physician, or medical practitioner in the Province of South Australia for a period of five years prior to the passing of this Act, nor to places where there is no legally qualified medical practitioner or coroner of the said province as aforesaid, residing within a distance of five miles.

6. If any legally qualified medical practitioner shall be convicted of any felony or misdemeanour, or be deprived of his qualifications by the college or body which may have granted the same, the Medical Board may, if they see fit, cancel or suspend the certificate of such practitioner, and such practitioner shall, upon the cancellation or during the suspension of his certificate, cease to be a legally qualified medical practitioner.

7. The Board may question any person who may attend before them, and any witness who may be pro-

duced before them, and may take a solemn declaration from such person or witness; and if any person shall wilfully, knowingly, and corruptly make any false statement upon such examination or in such declaration, or shall utter or attempt to utter or put off as true before them any false, forged, or counterfeit degree, diploma, testimonium, license, certificate, or other document, or shall wilfully procure or attempt to procure himself to be registered by making or producing, or causing to be made or produced, any false or fraudulent representation or declaration, either orally or in writing, every such person so offending, and every person aiding and assisting him therein, shall be deemed guilty of a misdemeanour, and shall, on conviction thereof, be sentenced to be imprisoned for any term not exceeding three years, and the registration so fraudulently procured shall be cancelled.

8. Any person who, previously to the passing of this Act, shall have received from the Medical Board a certificate of his being a legally qualified medical practitioner shall be deemed a legally qualified medical practitioner for all the purposes of this Act.

DEATHS FROM TYPHOID FEVER AND DIPHTHERIA IN MELBOURNE AND SUBURBS, FROM 1887 TO 1889.

The following is a statement of the deaths set down to typhoid fever and diphtheria in each of the first ten months of the present and the two previous years:

Month.	Deaths from Typhoid Fever.			Deaths from Diphtheria.		
	1887.	1888.	1889.	1887.	1888.	1889.
January ...	40	39	70	1	5	15
February...	70	63	64	4	2	13
March ...	59	54	91	3	13	18
April ...	57	43	113	6	13	26
May ...	40	32	92	10	19	35
June ...	15	20	36	7	16	30
July ...	15	12	17	9	14	48
August ...	9	9	16	7	11	36
September ...	7	9	6	7	11	37
October ...	5	10	6	4	9	21
Total ...	317	291	511	58	118	279

CHARTS OF THE HUMAN BODY, showing the skeleton and bones, viscera in position, heart and lungs, nerves, organs of senses, &c. Three plates, coloured, on canvas, with rollers, each 36 x 25 inches, the complete set, 22s. 6d., including descriptive text. Sold by L. Bruck, Sydney.

MR. BRUCK has received a full supply of Von Ziemsen's Pulmonary Tuberculosis; Erlenmeyer: Treatment of the Morphia Habit; Davenport: Diseases of Women; Bigelow: Gynecological Elektro-Therapeutics; Beale: The Liver; and many other new books, as per book list in this issue.

BOWRAL.—Dr. Wilson has superior accommodation for medical boarders.

BOOK NOTICE.

The American Armamentarium Chirurgicum. New York: George Tiemann & Co., 1889. We have received from Messrs. Tiemann & Co., of New York, the leading instrument makers in the States, a copy of the above work, their new catalogue of instruments, a handsome volume in small quarto of 846 pages, illustrated with over 1,400 engravings, and well bound in half morocco. A large number of operations are described in full, and in many instances the various methods of how to use the instruments accompany the engravings; a brief description of the surgical anatomy of the parts to be operated upon is also given, as well as a carefully prepared alphabetically arranged index and price list combined, showing at a glance the location of the engraving and the price of the instrument. The "Armamentarium" weighs 104 ounces, and is the most complete work of the kind we have ever seen, and in our opinion it should prove extremely valuable to the practising surgeon. We understand that the publisher of this journal has ordered a limited number of this novel and interesting work of reference which our readers may obtain from him at the nominal price of fifteen shillings, an amount which will hardly pay for its paper and binding.

THE MONTH.

NEW SOUTH WALES.

A COTTAGE hospital was opened on December 26th, at Bingera, in a mineral district, 352 miles N.W. of Sydney.

THE HONORARY medical staff at the Bathurst Hospital have resigned in a body. They state that they are unable to act with the resident medical officer.

A MEDICAL man is required for the district of Warren, on the Macquarie River, in a pastoral district, 353 miles W. of Sydney. An income of £400 per annum is guaranteed. Applications for the appointment to be sent to the undersigned on or before 31st January. Applicants are requested to forward credentials, and state whether married or single. Address, F. C. Tompson, secretary, Warren, N. S. Wales.

DR. GOODE, of Orange, who was defendant in the recent slander action Davis v. Goode, and against whom a verdict of £200 damages was returned, was on December 28th arrested by the Sheriff's officer for neglecting to pay the costs of the action, which amount to over £1000, and transferred to Bathurst Gaol. His reason for not paying the amount is that he would be thereby admitting the justness of the jury's verdict, and as his conscience tells him he was right in the course of action he took against the hospital matron, he is determined not to pay a penny but remain in gaol for his full term. A good deal of sympathy is now expressed for him, even by his opponents, who never expected that he should be punished in such an extreme manner.

THE Rev. Dr. William French Clay, M.A., Camb., M.H.C.S.E., M.D., Syd., who formerly practised at Wollongong and Manly, died in London on the 9th November last, at the age of 73 years.

WE sincerely regret to have to announce the death of Mr. James Smith, L.R.C.S. Ed., 1844, an old colonist of 45 years' standing, who died on December 10th, at his residence, Macquarie-street, Parramatta, in his 65th

year. The deceased gentleman formerly held for many years the position of resident medical superintendent of the Government Asylum at Liverpool, and also that of resident medical officer at the Sydney Lying-in Hospital and Benevolent Asylum; for nearly the last 20 years he practised at Parramatta, where his loss is deeply felt by a wide circle of friends.

THE sum of £2,100 has been collected for the erection of a hospital at Barraba, 339 miles N. of Sydney; Mr. A. S. Darby, of Campo Sauto, contributed not less than £1,500.

DR. ROBERT BOWKER has commenced practice at 195 Elizabeth-street, Hyde Park, Sydney.

DR. H. L. CUMMINGS, late of Braidwood, has commenced practice in Annandale, a suburb of Sydney.

DR. F. G. FAILES has returned from his trip to England, and resumed practice at Coonabarabran.

DR. ROB. FERGUSON and Dr. M. E. Wilkinson have been elected medical officers of the United Friendly Societies at Parramatta.

DR. W. F. GARRETT, late of Forest Lodge, Sydney, has been elected resident surgeon at the Bathurst Hospital.

DR. W. R. HAWKINS has removed from Brewarrina to Bourke.

DR. J. W. HESTER, of the Prince Alfred Hospital, Sydney, has been elected resident surgeon at the Newcastle Hospital, in the room of Dr. J. Kerr, resigned.

DR. T. R. HORTON, late of Grenfell, has been elected one of the medical officers of the United Friendly Societies at Balmain, near Sydney, in the place of Dr. Graham, resigned.

DR. N. R. HOWSE, a new arrival, has settled at Wallend, near Newcastle.

DR. J. A. LANGDON, late of Derby, Western Australia, and formerly of Westland, New Zealand, has succeeded to the practice of Dr. F. G. Connor, at Coraki, on the Richmond River, 349 miles north of Sydney.

DR. ALEX. MACCOEMICK, of Macquarie-street, has been appointed lecturer on surgery at the University of Sydney.

DR. C. H. MAHER has commenced practice at Burwood, a suburb 7 miles from Sydney.

DR. R. U. RUSSELL, late of the Little Bay Coast Hospital, near Sydney, has been appointed assistant medical officer at the Parramatta Hospital for the Insane.

DR. D. THOMAS, late of Kogarah, has succeeded to the practice of Dr. W. H. Tibbits, at Manly, a very favorite watering-place nine miles north-east of Sydney.

DR. H. G. S. WARREN, late of Dubbo, has commenced practice at Orange.

DR. WATT's medical hall at Cobar was destroyed by fire on December 23.

DR. W. CAMAC WILKINSON, Lecturer on Pathology at the Sydney University, now on his way to England, has been asked by the Government to visit France and Germany to make certain enquiries with regard to the reported discovery of the microbe of pleuro-pneumonia and allied matters, Dr. Wilkinson to be allowed £250 for his services and travelling expenses.

NEW ZEALAND.

THE death is announced of Mr. John Carey, M.R.C.S. Eng. 1853, L.R.C.P. Edin. 1859, who died at Forest Lake, Hamilton (Waikato), on December 8, at the age of 70 years. The deceased gentleman was an old colonist, and soon after arrival became attached to the local Government service. He was in the field with the colonial militia and volunteers from the commencement of the Maori war, and subsequently in 1863-64 he acted with the late Dr. Goldsborough as one of the medical officers of the Exemption Board. After the 4th Waikato Militia was formed he joined it as its medical officer and settled in Waikato, acting for some time as the resident surgeon at the Ngaruawahia Hospital. He had at the time of his death been long resident in Hamilton, being one of the very old identities, and had earned not only the esteem but the affection of those whom he had lived among during the last score of years. He leaves a widow and three daughters.

THREE natives—two women and a man—in the Bay of Islands district, have recently died from the effects of eating poisonous wild honey.

THE general and nursing staff of the Auckland Provincial Hospital have presented Dr. Bell with a set of teeth instruments, suitably inscribed, and Dr. Forbes with a silver cigarette case, as tokens of goodwill on their severing their connection with the Hospital.

DR. JOHN KERR, late resident medical officer of the Newcastle Hospital (N.S.W.), has commenced practice at Darfield, 30 miles from Christchurch.

DR. E. WADDINGTON has removed from Cambridge to Hamilton (Waikato), 86 miles S. of Auckland.

QUEENSLAND.

THE following medical practitioners have been appointed Justices of the Peace in Queensland:—Drs. W. C. C. McDonald, Ingham; J. S. Hunt, Hughenden; J. I. Moore, Springsure; F. H. V. Voss, Rockhampton, and A. J. McDonnell, Toowoomba.

WE learn from the home papers that Dr. J. H. Poland, of the Queensland Immigration Service, and well-known in Rockhampton, has devoted some time to the study of sanitary science and has obtained the diploma in Public Health of the Royal College of Surgeons, Ireland, and also the diploma in State Medicine and Sanitary Science of the College of Physicians, Dublin, two qualifications which are much sought after and a good deal thought of in Great Britain. We believe no other gentleman in Australia holds two such diplomas in Public Health, and as Dr. Poland is expected to return to the colony by the K.M.S. "Quetta" about the middle of February, it might be advantageous to one of the colonial Governments to secure his services.

DR. M. J. COLLINS has succeeded to the practice of Dr. W. L. Cranstone, at Clermont, 575 miles N.W. of Brisbane.

DR. J. L. CUPPAIDGE has removed from Toowoomba to One-mile, near Gympie.

DR. J. R. NICOLL, late assistant surgeon at the Hospital for Pacific Islanders in Mackay, has been appointed assistant superintendent of the Asylum for the Insane, Goodna, in the room of Dr. J. B. Hogg, who has been transferred to the Asylum in Toowoomba.

DR. K. I. O'DOHERTY has resumed practice in Brisbane.

DR. R. RENDLE has resumed practice in Brisbane, at Treasury Chambers, George street.

SOUTH AUSTRALIA.

ON December 18th the Chancellor of the Adelaide University (His Honour Chief Justice Way) conferred the M.B. and Ch.B. degrees on the following gentlemen:—Charles Henry Standish Hope, Frederick Goldsmith, Arthur Francis Augustine Lynch, and Cromwell Margery. In conferring the degrees the Chancellor congratulated the students on being the first to attain the degrees at the Adelaide University.

DR. E. E. S. COOMBE, a native of the colony, has returned from his studies in England, and commenced practice at Bowden, a suburb two miles from Adelaide.

DR. R. ST. M. DAWES, of Gawler, returned to the colony from his trip to England by the R.M.S. Austral.

MR. ALBERT WILLIAM WALLS, M.R.C.S. Eng. 1865, late of Mannum, and formerly of Hamley Bridge, is dead; the deceased gentleman arrived in the colony in 1866.

TASMANIA.

By an Act dated December 5, 1889, "The University of Tasmania" has been established at Hobart.

MR. JOHN BEST, M.R.C.S. Eng. 1833, L.S.A. Lond. 1832, late of Deloraine, and formerly of Cuckfield, Sussex (Eng.), died on December 16th, at the Invalid Depot, Launceston, at the ripe age of 80 years.

DR. W. A. HARRISON, formerly of Lyttelton and Dunedin (N.Z.), has settled at Strahan, on the West Coast.

VICTORIA.

THE Chancellor of the University of Melbourne, on December 21, conferred the following degrees:—

Bachelors of Medicine.—John Edward Barrett, Alexander Bruce Bennie, Edmond Joseph Gleeson, Patrick Francis Gleeson, Walter Thomas Harse, John Michie, Charles Albert Müller, John Melby Scott, Robert Glen Vickery, James Ramsay Webb.

Doctor of Medicine, ad eundem.—Harold Knowles Bean.

Bachelor of Surgery.—John Edward Barrett, Alexander Bruce Bennie, Edmond Joseph Gleeson, Patrick Francis Gleeson, Archibald Martin Macfarlane, John Michie, John Melby Scott.

THE following arrangements have been made by the Faculty of Medicine of the Melbourne University for the performance of Professor Allen's work during the year 1890, when he is to be absent on leave:—Dr. G. A. Syme to lecture on Anatomy, junior and senior; salary £250. Dr. W. Moore to lecture on Pathology, and conduct University demonstrations in pathology; salary £250. Dr. C. H. Mollison to act as demonstrator of Morbid Anatomy in the University, and pathologist to the Melbourne Hospital, the committee of the hospital to be asked to concur in the appointment; salary £100 from University, and £50 from Hospital, total £150. Dr. Howard to act as demonstrator of Anatomy, relieving Mr. Syme from the duties of that post, and receiving the salary thereof, viz., £100. Dr. Shields, as senior demonstrator of Anatomy, to have general charge of the dissecting-room, and to control the supply of subjects. Dr. Maudsley, to act as second examiner in Pathology, and to receive the usual salary, relieving Dr. Moore, who will be in the professor's place.

In 1889 no fewer than 74 state schools in all parts of the colony were closed for periods varying from one week to 12 weeks on account of an outbreak of fever,

or other disease, amongst the children. Thirty-three of the schools suffered from diphtheria, 17 from whooping-cough, 13 from typhoid fever, six from scarlet fever, four from ophthalmia, and one from croup.

THE NUMBER of cases of typhoid throughout the colony reported to the Central Board of Health for the week ending January 4th was 121, of which 12 were fatal. There were also 39 cases of diphtheria, 13 being fatal.

REGULATIONS have been drawn up with regard to the admission of patients to the Inebriate Asylum which the Government has established at Beaconsfield. Patients will be admitted on payment of £2 per week on the lower scale, and £5 per week on the higher scale. There are two buildings—one for male and one for female patients.

A LARGE gathering of members of the profession assembled at the Medical Society's Hall, East Melbourne, on December 11, when Professor Dr. Allen, Dean of the Faculty of Medicine, was presented with an illuminated address and a handsome bookcase and service of silver plate, in recognition of his services as honorary secretary to the Intercolonial Medical Conference, 1889. Professor Allen is on the eve of a prolonged visit to Europe, and it was thought that this would be a favourable opportunity for asking him to accept some tangible expression of the regard in which he is held by his confrères in the Victorian section of the conference.

PROFESSOR Allen, Lecturer in Anatomy and Pathology in the Melbourne University, was entertained at a dinner in the Town Hall, on January 6th, by the members of the Medical Society and his University and other friends, prior to his departure for Europe.

AT an inquest held on the body of an infant child, which had died at the residence of a Mrs. Parry, at Fitzroy (Melbourne), this woman stated that during the year about 15 children had passed through her house, of whom six died. The jury found that the child died from improper feeding, and added a rider that they were of opinion that such places as those kept by Mrs. Parry should be placed under proper supervision, and that a record should be kept of all confinements that occurred in these houses.

DR. A. O. BOBARDT has been elected resident medical officer of the Melbourne Hospital in the place of Dr. Drake, resigned.

DR. S. M. CAFFYN, of Melbourne, has succeeded in forming a company in England to take up his invention of an extract of meat, called "Liquor Carnis." Dr. Caffyn will be retained as general manager and superintendent of the factory, which will be in the colonies.

DR. F. J. DRAKE has resigned his position of resident medical officer at the Melbourne Hospital.

DR. JOHN DUFF, a new arrival, has settled at Harrow, 27½ miles W. of Melbourne.

DR. C. DURET, of South Melbourne, returned to the colony in the M.M.S.S. "Sydney" from his trip to France.

DR. G. R. EAKINS, of Echuca, met with a buggy accident on December 27 by his ponies bolting. The buggy was smashed, and one of the ponies so severely injured that it had to be shot, but Dr. Eakins and his groom fortunately escaped injury.

DR. E. G. FIGG, health officer at Williamstown, has resigned his position. Dr. McLean, the senior health officer, will perform all the duties until a successor is appointed.

DR. A. J. HAMILTON has settled at Wood's Point, 109 miles E. of Melbourne.

DR. JAS. JAMIESON, lecturer on the theory and practice of medicine at the Melbourne University, has been granted nine months' leave of absence, to commence from the 7th March, 1890, to enable him to visit the leading medical schools of Europe, and to observe the improvements which had been effected in medical teaching, and especially in methods of clinical science.

DR. JOHN JOHNSTON has removed from Nathalia to Williamstown.

DR. R. W. LEWERS has resigned his appointment as assistant resident medical officer at the Melbourne Women's Hospital.

DR. H. P. MARTELL has been appointed assistant resident medical officer at the Women's Hospital, Melbourne, in the place of Dr. Lewers, resigned.

DR. W. P. NORRIS has removed from Coalville to Colac, in the Western District.

DR. SIDNEY PLOWMAN, late examiner in chemistry to the Pharmaceutical Society of Great Britain, and tutor and joint lecturer in materia medica and therapeutics in St. Thomas's Hospital, London, has been appointed to lecture on chemistry, physics, and materia medica, as well as to direct the chemical laboratory in the College of Pharmacy, Melbourne. He will also instruct the University medical students in pharmacy at the same school.

DR. SPARLING, formerly of Hawthorn, has now commenced practice at Malvern Road, Toorak, a fashionable suburb of Melbourne.

DR. A. H. STURDEW has removed from Yarraville to Frankston, 27 miles S.E. of Melbourne.

DR. G. A. WEBSTER has commenced practice at Toorak Road, South Yarra, a suburb 3 miles S.E. of Melbourne.

DR. HENRY WHEELER, of Collins Street, has been appointed an honorary medical officer to attend to the out-patients' department of the Homoeopathic Hospital, Melbourne.

WESTERN AUSTRALIA.

DR. G. F. MCWILLIAMS, late of Woodend (Vic.), is now practising at York, on the Avon River, 60 miles E. of Perth.

MEDICAL APPOINTMENTS.

Copland, James, M.D. et Ch.M. Aberd., to be Public Vaccinator for the District of Gora, N.Z.
Denning, John Vere Charles, L.R.C.S. Irel., L.K.Q.C.P. Irel., to be Health Officer for Shire of Minnamit, Vic.
Hamilton, Alfred James, L.R.C.P. et R.C.S. Ed., L.F.P.S. Glas., to be Public Vaccinator and Health Officer for Wood's Point, Vic.
Mann, James, L.R.C.P. et R.C.S. Ed., to be Vaccinator for the District of Canterbury, N.S.W.
Simpson, Donald, M.B. et Ch.M. Glas., to be Health Officer for Fernree Gully, Vic.
Sturdee, Alfred Hobart, M.R.C.S. Eng., to be Public Vaccinator at Frackton, Vic., vice Dr. G. F. Atkins, resigned.
Tenant, Thomas Hately, L.F.P.S. Glas., to be Government Medical Officer and Vaccinator for the District of Tenterfield, N.S.W.
Theod, Stanley Vipan, L.R.U.P. Ed., M.R.C.S.E., to be Health Officer for Shire of Filders and Kangerung, Vic.

BIRTHS, MARRIAGES AND DEATHS.

. The charge for inserting announcements of Births, Marriages, and Deaths is 2s. 6d., which should be forwarded in stamps with the announcement.

BIRTHS.

CAMPBELL.—On the 9th December, at Adelaide, the wife of Dr. W. M. Campbell, of a daughter.
DAVENPORT.—On the 6th December, at St. Kilda, Melbourne, the wife of Dr. A. F. Davenport, of a daughter.
TWYNAM.—On the 8th January, at Darlinghurst, Sydney, the wife of G. E. Twynam, M.R.C.S., of a daughter.
WARREN.—On the 27th December, at Kew, Melbourne, the wife of Dr. W. Warren, of a daughter.
WARREN.—December 27th, at Leichhardt, Sydney, the wife of J. Montelth Warren, M.D., M.Ch., of a daughter.

MARRIAGE.

BOWKETT-LAMONT.—On the 16th December, at Herberston, North Queensland, by the Rev. White, William D. Bowkett, M.R.C.S., L.S.A., to Eva Frances, eldest daughter of the late E. W. Lamont of Melbourne.
HUGHSTON-SMITH.—On the 29th November, at the Presbyterian Church, East Brisbane, Robert Wilson Hughston, M.B., B.S., of Camberwell, Melbourne, to Grace Mary, eldest daughter of the Rev. A. C. Smith, East Brisbane.

DEATHS.

HANSARD.—December 18th, at Petersham, (Sydney), Jane Catherine, wife of Dr. Hansard, aged 73.
PENFOLD.—On the 23d December, at Sandhurst, (Vic.), Mary Louisa wife of O. Penfold, M.R.C.S.
SEDGWICK.—December 25, Charlotte Jane, eldest daughter of W. G. Sedgwick, surgeon, Newtown, (Sydney).
SKINNER.—On the 5th January, at Beechworth, Victoria, David Morton, third child of Dr. D. Skinner, aged 2 years and 4 months.
SMITH.—December 24th, at Cowra, N.S.W., Dudley de Courcy, aged 10 years, only child of Edward R. Smith, M.R.C.S.E., &c.

PUBLICATIONS RECEIVED.

El Arsénico como Profiláctico del Tifo, por el Dr. Samuel Morales Perrira. Mexico, 1889.
Fruit Blights and Diseases of Fruit-trees. Interim Report. By Professor F. Kirk, F.L.S., of Wellington, N.Z. Reprinted by permission of the Government of New Zealand. Sydney: Charles Potter, Government Printer, 1889.
The Annual Report of the Health of the Imperial Japanese Navy for 1888.
The Typhoid Germ: its recognition, propagation, and eradication. A Lecture delivered under the auspices of the Australian Health Society. By J. W. Springthorpe, M.A., M.D. Melbourne: Stillwell & Co., 1889.
Views on the Prevention and Treatment of Typhoid Fever. By Stephen Smith Burt, M.D. (From the *New York Medical Journal*, March 2nd, 1889).
Electricity in the Treatment of Uterine Tumours. By Thomas Keith, M.D., LL.D., Edin., and S. Keith, F.R.C.S., Edin. Edinburgh: Oliver & Boyd, 1889.
The Diagnosis and Treatment of extra-Uterine Pregnancy. By John Strahan, M.D., M.Ch., M.A.O. (Royal Univ. of Ireland). Philadelphia: Blakiston, Son & Co., 1889.
Anæsthetics: Ancient and Modern. By George Foy, F.R.C.S. London: Baillière, Tindall, & Cox. 1889.
Cancer and its Complications. By Charles Egerton Jennings, F.R.C.S., Eng., M.S., M.B. London: Baillière, Tindall, & Cox. 1889.
Dermoids: or tumours containing skin, hair, teeth, &c. By J. Bland Sutton, F.R.C.S. London: Baillière, Tindall, & Cox, 1889.
The American Armamentarium Chirurgicum. George Tiemann & Co., New York, (1889).

NOTICE OF REMOVAL.—Mr. R. B. JOB, Massage, Galvanism (London Certificate), 81 Phillip-street, Sydney.

AUSTRALASIAN MEDICAL GAZETTE.

ORIGINAL ARTICLES.

NOTES ON CERTAIN METHODS OF TREATING CONSUMPTION OF THE THROAT.

READ BEFORE THE MEDICAL SECTION OF THE ROYAL
SOCIETY OF N. S. WALES.

By WM. F. QUARF, B.A., M.B., GLAS.

THE disease above named has for a long time past been the subject of discussion among the profession; not so much from the point of view of its pathology, which is indeed fairly well established, nor yet from that of its prognosis, which is unfortunately only too certain, as with respect to its therapy.

The expectations in the mind of the experienced physician on this subject are a quantity variable inversely almost with the multiplicity of treatments that have been adopted. It seems so impossible to bring up the degraded tissues to a mark that will react by throwing off the disease-germs or the poison they generate that many have practically given the matter up in disgust, and resort to therapeutic methods by way only of routine and merely with a view to soothe and pacify their patients. It is an undoubted fact that in the struggle for life the bacillus usually comes off better than the degraded protoplasm of the higher organism; and that those medicaments which are able to poison and eradicate the parasite are still more likely to kill the tissues of its weakly host. And thus every thorough and candid observer has instinctively felt that the only key to success is the natural strength or artificial enervation of the patient's system; and that without this foundation any local application of antiseptics that may succeed in driving away the disease-germ from its hunting ground has only to be abandoned for a time to give its enemy full dominion again either in actually the same or some more or less associated spot; and this statement is, perhaps, with some antiseptics all the more true from the irritant and depressing effect caused by them upon already weakened tissues. Thus, with respect to phthisis pulmonum, so far as I am aware the majority of physicians have practically thrown aside the use locally and internally of antiseptics; the administration of creasote, carbolic acid and iodine by the stomach; the actual forcing of oily preparations of iodoform or creasote through the walls of the chest into the substance of the lung; the inhalation of creasote, aniline, wood-tar, and other antiseptics in spray or otherwise, and half a dozen other

specifics which might be mentioned are read of only in antiquated works, or revived in new forms in each forthcoming medical annual. And we have fallen back on schemes of compressed air that will hyperoxygenate the blood, and more highly nourishing foods that will strengthen and replace the wasted protoplasm; and we have come to value more highly than ever after some slight neglect the natural remedies of exercise and fresh dry buoyant air. Still after all there is no doubt that part of the ill success attained by the methods just spoken of in disease of the lungs arises from the impossibility of bringing the materials into contact with the diseased tissue; and many of them have an *a priori* value not only as antiseptics but also in the way of soothing and stimulating the tissues to a healthy action. And, therefore, we might have some reason for believing that in parts more accessible than the interior of a choked and occluded lung they would have a beneficial influence more or less marked upon masses of degraded tissue by stimulating as alteratives their induration and absorption, as well as by their antiseptic action of paralyzing the tubercle bacillus or driving it away. One is thus on theoretic grounds more disposed to view with favour the application of balsams and alteratives to tracts in the windpipe and pharynx than to parts further remote; and I wish to draw your attention to the results more especially of the use of certain of these substances in my practice during the last twelvemonth.

I should first like to mention the older topical applications of which I have had more extended experience. These are, first and foremost, the nitrate of silver, glycerine of iodine, and iodoform as alteratives; compound tincture of benzoin, creasote, hemlock juice, and sulphurous acid in steam as local sedatives, also a mixture of starch, oxychloride of bismuth and morphia insufflated; and finally as an expectorant taken internally on sugar Terebene.

In Vienna, when I was there, the routine treatment of these cases was, for hyperæmic conditions, 5 per cent. to 10 per cent. solutions of nitrate of silver and, where there was much discharge or ulceration, iodine in glycerine or iodoform powder, and I am bound to say that the results were anything but encouraging. The silver salt, in spite of what is said about its sedative action, often kept the irritation going, and the iodoform, while acting as an anodyne, never reduced the discharge one whit. The morphia insufflation is of less value than iodoform as an anodyne, unless given in quantities that rapidly reduce the patient's vigour, and I think it should

never be administered in such cases except at the very last. As for the steam inhalations, they are all of great value in diminishing pain and coughing, especially that of alkaline hemlock juice. Terebene, on the other hand, is a most excellent expectorant and carminative, and will be found of great service at most times. But, summing up these remedies, they are at best and at all stages palliative and nothing more, and if we are to entertain the idea of a cure further search becomes necessary. The only two substances that have in any degree repaid this search are lactic acid and menthol.

The former of these remedies was introduced in 1886 by Krause, of Berlin, and Hering, of Warsaw. Lactic Acid is, of course, at least in its full strength of S.G. 1.210, to some extent an escharotic, and destroys or at any rate violently inflames the tissues with which it comes in contact. But its adherents tell you that the inflammation which is thus produced is essentially a healthy active one, free from any tubercular taint, and that when it subsides all trace of tubercle is gone from the part. Further, they say that even in weaker strengths lactic acid shows the same incompatibility with tubercle, and by thus mitigating the caustic you may reduce the reaction and yet drive away the disease. In other words, lactic acid acts constitutionally as well as locally. In favour of this view it appears that in 10m. doses it has been used for tuberculous diarrhoea with immediate and permanent benefit, acting, it is supposed, upon the anæmic and ulcerated parts of the intestines in the same way as upon the larynx. As a matter of fact, there can, I think, be no doubt that in the majority of cases such a vigorous reaction is set up by the stronger applications of lactic acid, provided that the system of the patient be not yet too feeble to so react, and that for the most part what is apparently or even really a healing ulcer is produced. In the intestine it is, of course, impossible to say how far the cicatrization goes on, but the non-recurrence of the diarrhoea is surely no proof of the complete healing of the ulcers in question when we consider the capricious way in which, in some of these cases, diarrhoea comes and goes and our uncertainty as to the ulcers being the cause of the discharge at all. With respect to the throat, there is no doubt that in the more vigorous of the patients, and in those cases where the pharynx is more especially affected, much healthy cicatrization may be thus induced, and by the consequent relief to pain and discomfort a valuable change in the general condition set up. But this does not prove a cure of the disease; the amelioration in the condition is due to relief of the pain and dysphagia; and in the depths of

the larynx, where the ulceration is accompanied with but little pain and usually no dysphagia at all, it does not appear that a similar constitutional reaction is set up. It may, of course, be said that the disparity is due to the overt or latent and undiscoverable presence of tubercle in the lungs in laryngeal disease, which does not exist in the pharyngeal cases. This is a matter which only experience can show, but I have at any rate Lennox Browne to fall back upon, where he says that for phthisis of the larynx he has practically discarded lactic acid. And from what statistics I can gather I gain the impression that disease of the lungs is quite as often undiscoverable in phthisis of the larynx as of the pharynx: i.e., proportionally, the latter being by far the more uncommon disease. An undoubted argument against the endolaryngeal use of lactic acid is its fluid nature; when introduced there is, in spite of cocaine, oftentimes a certain amount of spasm, and especially if a large surface of ulcer is touched the acid spreading over the remainder of the mucous membrane sets up at times an excessively violent reaction, the more so as it is practically useless to apply anything weaker than a 60 per cent. solution.

And in the next place arises the question as to the constitutional effect of lactic acid. On this point it would be presumptuous to offer any suggestion as little is known of the action of this drug; it does not appear on the one hand that the rheumatic diathesis, in which lactic acid is supposed by some to play an important part, is antagonistic to the tubercular; on the other, it is very seldom that one finds a tubercular ulcer in the stomach, an important part of whose secretion is lactic acid. If there be no such antagonism, it would appear therefore, *a priori*, in laryngeal cases, a more rational thing to replace the fluid and somewhat unmanageable caustic with the completely controllable galvano-caustic point. I have done this on two occasions in my own practice, and on each occasion found the reaction very trifling, the pain nil, and the destructive action quite as marked. I was only dissuaded in these cases from further use of this medium by the doubt whether after all much constitutional benefit were afforded the patient by the procedure. But, at any rate, I should be much more willing to recur to its use than to harass my patient with the lactic acid treatment, followed by curetting as some authorities recommend.

The treatment of these cases with menthol preparations is also now of some little standing, having been introduced by Rosenberg, in the year 1886, and tried by him for some time. It is much easier to understand how this substance should have been adopted for throat disease than

Lactic acid. The use of substances like Peruvian Balsam, Camphor and Turpentine as inhalations for the chest and throat is a very old one, as any pharmacopœia will testify; and the more stimulating aromatic oils have been especially in favour. And since the introduction of the antiseptic principle any of these substances to which such properties were attributed would be specially in demand.

Menthol is the Stearoptene of the essential oil of the true mints, and is obtained from these plants principally in America and Japan. In its chemical analogies and therapeutic properties it corresponds to the Stearoptenes of most other essential oils, such as Pumilio, Pinus Sylvestris, Eucalyptus, Thyme, etc., and is allied to the resins of the Balsams. Like Thymol, Phenol, and Camphor, it is a true monatomic alcohol, having one of the atoms of hydrogen replaced by an hydroxyl molecule. The Stearoptene which it actually most resembles in therapy is that of Clove oil. It has much less of the true antiseptic properties than Thymol, Eucalyptol and Phenol, but it makes up for these like Clove, Stearoptene, in the numbing effect upon the sensory and vaso-motor nerves; it is a cardiac stimulant, carminative, and what would be called antispasmodic. As to the action of these alcohols on the granulations of ulcers experience goes to show that in antiseptic power Clove oil and Menthol are very deficient, and that Phenol and Clove oil are excessively stimulating to the granulations. In many cases it is well known that carbolic solutions directly applied to an ulcer make the granulations fungate and delay the closing in of the skin; I am not aware if Menthol does the same thing when applied to skin-ulcers, and should be glad to be informed on this point. But besides their action as a cardiac stimulant, there is another property which many of these higher alcohols enjoy in common to a greater or less extent, viz., the anæsthetic power. Thus, then, compared with other bodies of this series, Menthol, as an application to ulcers, ranks high in destroying pain and in increasing the capillary circulation of the part; as an antiseptic, as an alterative, and as a destroyer of tissue it is of little value. Its action is best seen upon unbroken mucous membrane, such as that of the nose or pharynx, when these structures are dry and glazed; it numbs the pain, and rapidly produces glandular secretion in consequence of the vaso-motor dilatation set up. Those who have suffered after a day's nervous excitement from a nocturnal dryness of the nasal passage, and have tried the inhalation of the vapour of a piece of warm menthol are very well aware how rapidly the pain subsides and sleep comes on. Menthol is at an advantage when used in closed cavities in this way, as unless enclosed

under a plaster its volatility renders the skin action very fugitive indeed. Practically as an application in throat disease of various kinds, for convenience of application and comfort to the patient, I should place it as an anæsthetic very far behind Cocain, to which, however, it bears in its action a great resemblance; on the other hand, for durability of effect and certainty of result, it supersedes that drug. It is, indeed, very useful in those cases where there is deficient secretion, and in those special cases of nasal obstruction due to dilatation of the cavernous tissue of the turbinated bodies. But in such cases I would urge caution in the strength of the application; I have known of extreme pain and even temporary collapse having been produced by the use of a powder containing it, as when one had inhaled strong ammonia gas. Finally, to come to the disease in which Menthol has been most vaunted by its introducer, Rosenberg and others; I have made use of this substance in consumption of the throat in a number of cases during the last twelve months. In the greater number of these cases there was considerable diminution in the pain and in the amount of discharge; and in consequence, as I take it, an increase in appetite and in the actual assimilation of food resulting in greater body weight. This went on for some time, until the heat of the summer and the influence of the sea breezes depressed the strength of the patients so much that they had to be sent into the country, where, I am sorry to say, the ulceration steadily increased, and the strength went down as the lungs became involved. In two cases that I have had more recently of newer arrivals in the country, the Menthol preparations failed from the first to control the suppuration. I am sorry to say that I cannot recall any case in which Menthol has been of permanent benefit. In most, except for the nastiness of the oil and mint flavour, there has been a feeling of warmth and comfort and a diminution of the hacking cough, and a consequent relief from the more pressing symptoms which has led the patients to believe that they were deriving substantial good, but unfortunately only for the time. There were only a few of the total number of cases of phthisis laryngea which seemed especially favourable for the trial of Menthol, viz., those in which the lung trouble was trifling in its nature. In most of these the lung disease made headway against the remedy in spite of deep tracheal introductions of the oily medium, and in the solitary instances where it did not the subject seemed to emaciate and perish away almost as fast as if it had. In the employment of the Menthol preparations a kind of combined syringe and spatula made of glass was used at first by the patient;

it was, however, found that as often as not this instrument slipped aside, depositing the oil in one of the pyriform spaces or oesophagus. I therefore came to insist on applying the oil myself with a cotton-holder or vulcanite syringe having a long nozzle. I never in any case used it in powder, believing the mechanical action to be too irritant, and the alcoholic and æthereal solutions are almost as bad. Thus, then, with respect to Menthol, so far as my experience goes it tallies with that of McBride, who cannot in the whole of his practice call to mind more than one even temporary cure. I hear that even Rosenberg has expressed himself disappointed, and has largely fallen back on the old lines of treatment. It would certainly appear that if Menthol is not going to cure it might in a number of cases be superseded by less disgusting remedies. It certainly is an undoubted fact that these cases do occasionally heal up spontaneously, so far as the throat is concerned; there are cases in Gottstein and other writers to prove this. But that any local remedies whatever have more than a secondary influence upon their cure is another matter altogether. And, as Gottstein says, "It appears that even in the most promising of these cures, almost without exception we find after a longer or shorter time on the originally diseased spot or some other in the larynx a return of the disease, which usually finally puts an end to the patient's life."

It appears, therefore, to be only in the earlier and milder grades of the disease that any possibility of cure is to be thought of; when the mucous membrane of the parts has even reached the stage of the "pyriform swelling" or the "turban-shaped epiglottis," we have little to expect except mitigation of pain and an euthanasia. And thus in these early stages some mild astringent, more especially the 10 per cent. (or weaker) solution of silver nitrate, or a similar strength of perchloride of iron may be recommended. Spasm is relieved, in my experience, better by the alkaline inhalation of hemlock vapour than by anything else, this substance being a pure sedative without stimulation. In the later stages, when there is dysphagia with excessive discharge from the ulcerated surfaces, an 8 per cent. solution of Cocain in spray is at first very effective, and after it has ceased to do good we may rely for a while upon Menthol dissolved in oil or a fine insufflation of iodoform, with or without starch and morphia. At this stage any form of astringent applied to the raw surfaces will only increase the formation of pus and cause pain. The tincture of sanguinaria may perhaps be excepted from this condemnation; it is a very mild astringent without irritant

qualities, and seems sometimes to check the discharge; a fluid extract would probably be still better. This is about the time when abscesses are liable to form, from the extension of disease to the cartilages, and when the use of the rectal or oesophageal feeding tube is demanded.

Of all the cases seen by me during the past year, nearly 30 in number, more than half were so advanced as to seem unsuitable test cases for the treatment of which mention has been made, and in rejecting these an arbitrary standard was set up, depending entirely on the amount of hectic and wasting. In those two or three cases where no disease, or next to none, of the lung was discovered, I regret to say that the ultimate issue was as bad as might be expected; in one case, more especially, a great degree of emaciation was attained before any dulness or tubular breathing exhibited itself, and singular to say, it was these mildest cases that went off from tubercular meningitis. As a rule no favourable prospect can be given of any case after it has passed the stage of catarrhal laryngitis, with slight cogwheel respiration; and only within limits can we even look for a prolongation of life.

NOTE.—This paper was recently read before the Royal Society. In the discussion which ensued Dr. Shewen mentioned that he had, among other substances of an antiseptic and alterative nature, made use of menthol in a number of pyrexial cases of consumption of the lungs. The menthol was dissolved in cod liver oil to a strength of 20 per cent. and injected after performance of tracheotomy in the quantity of m. 15 or 20 . A feeling of lightness and ease was perceived by the patients after each injection, and the discharge was then usually more mucoid in character, but the pyrexia and the progress of the disease were unaffected. This series of cases was in the wards of the Prince Alfred Hospital, under the most favourable conditions for treatment.

POISONING BY BELLADONNA LINIMENT.

By WALTER B. NISBET, M.B. ET CH.M.

THE number of recorded cases of poisoning by belladonna seem to be so few that I send you notes of the following:

On December 21, 1889, M.M., aged 61, at half-past three in the afternoon, swallowed by mistake half-an-ounce of liniment of belladonna with which was mixed a small quantity (12 per cent.) of liniment of chloroform.

Though aware of the mistake he refused to allow medical advice to be sought. At half-past four he began to feel drowsy, and at five o'clock

was carried to bed in an unconscious state by his friends. I arrived at half-past five and found him lying stretched on his back perfectly unconscious; conjunctivæ insensible to touch; pupils medium, not reacting to light; breathing regular but deep, 16 per minute; skin dry; pulse 75; temp. 98.6°; slight convulsive movements of the extremities.

The stomach pump was used at once, but the water injected returned quite clear with the exception of a little mucus. At the end of the operation half-a-grain of morphia was given hypodermically.

At half-past six a fine punctate rash made its appearance over the chest, abdomen and upper arms. Pulse 120; temp. 102°; otherwise condition uncharged.

At eight o'clock $\frac{1}{4}$ of a grain of nitrate of pilocarpine was given by the skin, and a small quantity of brandy was with difficulty got down his throat. When called by name loudly the eyelids were raised for an instant and closed again, but conjunctivæ still insensible to touch. Rash disappearing; convulsive movements the same; pulse, 124; temp. 102.4°. Profuse sweating came on three-quarters-of-an-hour after the pilocarpine was injected, without making any material change in the condition.

He remained in this state all night till six a.m. when the pulse fell to 104; temp. 100°. A hypodermic injection of $\frac{1}{4}$ grain of morphia and $\frac{1}{6}$ grain of pilocarpine was given. Sweating followed almost immediately, and from this time he began to improve. Brandy was given in small quantities, and he slept all that day and night awaking the following morning perfectly well but remembering nothing from the time he took the liniment. The pupils were *never dilated*, remaining of medium size and unaltered throughout.

A specimen of the same liniment was analyzed and found to contain nearly 2 grains of atropine in 2 fluid ounces, being therefore fully up to strength. It is calculated M.M. took a quantity equal to 160 grains of powdered belladonna root, or $\frac{1}{2}$ a grain of atropine. Taylor in his Medical Jurisprudence records a fatal case of poisoning by 80 grains of the root given per rectum, so that the rapid recovery in an old man after taking twice that quantity may be regarded as remarkable.

The most interesting point in the case, however, appeared both to Dr. Humphry (who was associated with me in the treatment) and myself, to be the absence of dilatation of the pupils which would tend to show that what we are inclined to regard as infallible symptom of belladonna poisoning may be altogether wanting.

Townsville, Queensland.

TWO CASES OF COMPOUND DE-PRESSED FRACTURE OF THE SKULL IN CHILDREN.

READ BEFORE THE MEDICAL SECTION OF THE ROYAL SOCIETY OF NEW SOUTH WALES.

By W. H. GOODE, M.A., M.D. ET CH.M.
DUBL., HON. SURGEON TO THE SYDNEY HOSPITAL.

I BRING before you to-night two children who received severe injuries of the skull from the effects of which, as you may see, they have perfectly recovered. One would never think from the appearance of the little girl, with her bright intelligent face, that she had lost a considerable portion of her brain.

C. M., aged five years, was admitted into the Prince Alfred Hospital at eight o'clock at night on Friday, November 11, 1887. He had on that afternoon, when running after his hat, which had been blown off by the wind, gone over the edge of a quarry and fallen to the bottom, a distance of 46 feet. His fall had not been broken in any way. On an examination being made the boy was found to have received a compound depressed comminuted fracture of the left parietal bone and a slight wound of the skin on the left wrist. The opening in the scalp was small—about three-quarters of an inch in length—and the depressed portion as felt through the integuments was of an elliptical form, the long diameter of which measured two-and-a-half inches. He had paralysis of the right leg. The scalp was divided and retracted when it was found that a number of fractures radiating from the central point of the long axis of the depressed portion to its margin existed. There was also a fracture, the edges of which were about one-sixteenth of an inch apart, extending downwards and backwards as far as the probe reached in the direction of the foramen magnum. The edge of the depressed portion was driven under that of the uninjured bone at its posterior and upper margins. This overlapping portion was cut off with a Hey's saw, and some of the depressed pieces were removed and others elevated. A depressed bit attached by a small portion of the inner table, and which measured about an inch-and-a-half in length, was elevated and left with the hope that its outer surface would exfoliate, and that the remainder would live and thus help to fill up the opening in the skull. After the loose portions had been removed a gap remained which measured an inch-and-a-half by one inch at its greatest diameters. A small

opening in the dura mater one-eighth of an inch long was sutured with fine carbolized catgut. The edges of the fracture extending downwards did not come together, but remained about one-sixteenth of an inch apart. The scalp was sutured with horse-hair, and an indiarubber drainage tube inserted, the ends of which projected from the extremities of the wound.

At 11 o'clock on the next day the wound was dressed, when the boy showed signs of cerebral irritation. On awaking out of his sleep he cried out, but he did not articulate. He moved his right hand and arm as if he wished to remove something from his head. He did not move his left arm, but he opened and shut his left hand. He moved both his legs, and he took food well.

On the 13th he was rather better as far as movement was concerned, as he moved both legs and arms. He had been rather restless and cried out a good deal during the night, and his morning temperature rose to 101.7° F., which was the highest temperature reached during the progress of the case. He did not swallow so well as on the previous day.

On the 14th (third day) he could move all his limbs, but the movement of the left arm was more sluggish than that of the other limbs. He was not so irritable, and had no loss of sensation of any part of the body.

On the fourth day he was very irritable and would swallow nothing. All paralysis had disappeared, and for the first time since his admission he understood what was said to him and answered yes or no. As his bowels had not been moved since he received the injury he was given three grains of calomel.

On the fifth day he was very irritable and did not speak although conscious, and he threw himself about the bed. The calomel acted on the bowels, though the tongue was still furred but moist, and the wound looked well.

On the sixth day there was no irritability, and he took his food well.

On the seventh day the wound was suppurating freely, and he cried a good deal, as if in pain. He had slept badly during the night.

On the tenth day he spoke, but wandered in his converse, and he had no pain.

On the eleventh day he was quite rational; he had passed a good night and there was an abundant discharge of pus from the wound; he did not complain of any pain; his temperature rose to 100° F. in the evening, and bare bone was felt with the probe, corresponding in size with the large fragment which was attached by a portion of the inner table, and which had been left with the hope that it would retain its vitality.

On the fourteenth day he was very well and his temperature was normal. He improved daily, his temperature never again rose above the normal, the bare piece of the outer table came away and the wound healed well.

F. S., aged three years, was admitted into the Prince Alfred Hospital on February 12th, 1888. On the afternoon of that day she had fallen from a balcony twenty feet high on to the spikes of a paling fence. On her admission she was found to have a depressed compound fracture of the left parietal bone, and a quantity of brain substance had exuded from the wound. There was no paralysis. Chloroform was administered, when it was found that a piece of the skull resembling an arrow head in shape had been driven through the dura mater. This was removed and some large pieces of brain substance then came away. Three pieces of bone were removed, and after the edge of the uninjured bone had been cut away the depressed portions were elevated. The opening in the dura mater was sutured with catgut, the wound being well washed with a solution of corrosive sublimate, a drainage tube was inserted and the edges of the wound in the scalp were brought together with horse-hair sutures.

On the next day she had some cerebral irritation. She had passed a good night and she had no paralysis.

On the second day the wound looked well and she was quite sensible.

On the fourth day her temperature rose to 101° F. at night, and on the fifth day it rose to 104.5° and her body was covered with a rash resembling that of scarlatina. She was removed to the infectious wards, and on the sixth day her temperature had fallen to 103.2°.

On the seventh day it fell to 99.5°. The rash disappeared, and on the evening of that day her temperature was normal. She did well and the wound healed.

On the thirtieth day her body and thighs were found, at 11 o'clock in the forenoon, to be covered with a red rash, like a lobster, her temperature at the time being 102.6°; at 3 o'clock in the afternoon this rash had entirely disappeared and her temperature fell to normal. From this time she never had a bad symptom and she was discharged in perfect health.

In considering these two cases we find the boy fell from a very great height, 46 feet, and it seems very wonderful that he was not instantly killed. There was no apparent injury to the brain substance, yet he had paralysis. In the case of the little girl the injury to the brain seemed of a very serious nature, yet she had no paralysis and was perfectly sensible the day after the accident.

CASE OF TRANSFUSION.READ BEFORE THE MEDICAL SECTION OF THE
ROYAL SOCIETY OF NEW SOUTH WALES.BY RALPH WORRELL, M.D., M.Ch., Hon.
ASSISTANT SURGEON TO THE DEPARTMENT
FOR WOMEN AT THE SYDNEY HOSPITAL.

I HAVE brought this case of transfusion before you to-night feeling that the discussion and rehearsal of a procedure which in certain cases may be the only means of saving life, cannot be an altogether unprofitable employment of our time.

On the night of October 27 I was sent for to see a young girl who had been confined by a midwife 13 days before of her second illegitimate child. She had fainted twice during the evening and this had alarmed the people in the house and induced them to send for a doctor.

On my arrival, although the room was in partial darkness, I was struck by the extreme pallor of the patient, and felt sure I had to deal with hæmorrhage in some form. She was too weak to give any account of herself, but enquiry from the bystanders elicited that she had fainted immediately after the confinement, and again on the seventh day, as well as twice previous to my being sent for, and that bleeding had been going on continuously since the delivery. This was not considered unusual or important, and with the view of "strengthening her" she had been allowed up for a few hours the last two days. It was while sitting in a chair that the fainting had occurred this evening. The midwife who confined her was present and said she had only seen her twice since delivery, which was natural, except for the faint afterwards and a rather too free flow of blood. The after-birth, she said, came away all right.

The patient was very restless, the pulse a mere thread, 156 to the minute, temperature 108, respirations sighing and voice weak. On making a vaginal examination I found a profuse discharge of watery blood. In the vagina was what seemed like a bag of coarse sand, but which I soon found to be the placenta, which had undergone calcareous degeneration and was firmly attached to the almost completely inverted uterus. Owing to the relaxed condition of the parts reduction was easy, but some little difficulty was experienced in peeling off the placenta. The uterus was drenched with hot carbic water and then with perchloride of iron and water, 1 in 20. By this time the pulse was uncountable and the tendency to faint marked. I gave half-dram of ether hypodermically, and finding this had no effect determined to try transfusion as a last resource. The apparatus used was a pint douche can with a rubber tube attached, into the other end of which I inserted a canula of my

aspirator. A teaspoonful of salt was dissolved in a pint of water at about blood heat, and with the help of Dr. A. T. O'Reilly, I proceeded to open the median basilic vein, which showed more prominently than the median cephalic. A string having been tied around the upper arm the vein was exposed by a transverse skin incision, there being so little subcutaneous tissue that great care was necessary to avoid an accidental wound. The vein was then lifted up by a director passed beneath it and a small longitudinal opening made to admit the canula. The blood which flowed out was thin and watery, in fact merely serum. While the saline solution was flowing from the canula this was inserted upwards into the vein, and the can raised only slightly above the level of the patient so that the fluid should not enter at too great a pressure. When about one third of the pint had entered a distinct improvement took place, the pulse became fairly regular, 144 to the minute, and the patient said "I am better now." Unfortunately I continued to allow the solution to flow, and in a few seconds the pulse failed again, the respirations became laboured, and the patient much distressed. I immediately ceased the transfusion, but the symptoms grew worse, there were the terrible precordial anxiety, pains and oppression in the chest, gasping for breath, and other symptoms characteristic of capillary thrombosis. At this juncture Dr. Knaggs arrived and suggested a hypodermic of morphia and atropine, which I gave with some relief to the distress, but the patient was evidently past all aid, and died just three hours after I entered the house. The transfusion in this case had a distinct but very temporary good effect. Perhaps if I had ceased directly the improvement occurred the result might have been different, but I do not think so, as owing to the septicæmia which was undoubtedly present, we had to deal not only with a dangerously diminished quantity, but also with a poisoned quality of blood. In the exhaustive lectures on transfusion by Dr. William Hunter, delivered before the Royal College of Surgeons and published in the *British Medical Journal* for April last, it is clearly shown that the distressing disturbances sometimes seen to follow transfusion are due to capillary thrombosis and not to any over-filling of the system with blood or too rapid injection, which are usually considered the producing causes. Why this capillary thrombosis should occur in one case or experiment and not in another is as yet not clearly understood, but everything points to the condition of the recipient's blood at the time of operation as the main factor. It is much more likely to follow the injection of blood than of saline solution, wherefore I selected the latter, although five individuals

in the house offered to give their blood. Defibrinated blood is more dangerous than ordinary blood because the proportion of the white corpuscles is much higher, and the disintegration of these and the blood plasma seems to be the immediate cause of thrombosis. Dr. Hunter lays stress on the fact that the chief value of transfusion is physical, restoring a volume of fluid to the vascular system sufficient to enable the circulation to be carried on. Blood possesses in addition a physiological value in its greater power of stimulating the vaso-motor centres, but this advantage is more than counterbalanced by the greater difficulty and danger attending its use. Great care should be taken to see that the temperature of the solution should not be above that of the body.

A CASE OF PULSATING TUMOUR OF THE ORBIT.

By A. G. E. NAYLOR, L.R.C.P. ET R.C.S. ED.,
OF SWANSEA, TASMANIA.

It is my good fortune to have under my care a case of Pulsating Tumour of the Orbit, which, on account of its rarity (many medical men having probably gone through life without having seen the condition), seems worthy of being recorded.

Mrs. M., aged 60, has a very good family history. During girlhood she had measles severely, leaving behind an affection of the eyes, which necessitated her attendance at the Moorfields Hospital, London. She is of full habit, and the hepatic diathesis. She has had fourteen children and five miscarriages. She had accidental hæmorrhage with the birth of one of her children twenty years ago. Fifteen years ago, and nine months after the birth of her last child, she had an attack of Epistaxis, and since then she has been subject to repeated attacks of it, one of them having required plugging of the nares. She came under my charge with one of these attacks, and since then I have treated her twice for the same trouble. In all three of them the bleeding was arterial, and I had to use ergot and syringe the nostrils with a weak solution of perchloride of iron to arrest it.

After the second Epistaxis for which I treated her (which was about eighteen months ago) she had a fit of retching, and shortly after perceived abnormal sounds and sensations in her head; the right eye began to protrude, and its vision became defective, of all of which symptoms she complained to me.

On examination I found exophthalmos and swelling of the lids and conjunctiva, pulsation of the eye-ball, ptosis, and a well-marked bruit over

the eye and all round the head. The ophthalmic vein and its branches were distended, and a small pulsating tumour formed from the vein, with a port-wine stained condition of the skin around that part of the forehead where the vena præfrontalis is. Orbital aneurism was diagnosed.

A year after these symptoms presented themselves the patient had another bleeding from the nose. Two mornings afterwards the conjunctiva of the *left* eye became very congested, with chemosis of the lids, gradually increasing till a pad of infiltrated mucous membrane projected between the lids. There was also protrusion of that eye-ball. These symptoms are all still present, but in a somewhat lessened degree.

The treatment has been—as much rest as possible, with iodide of potassium internally, and careful dieting, with occasional daily pressure of the right common carotid. Unfortunately, the patient cannot be induced to submit to the absolute rest that might be beneficial; and ligature is out of the question with her.

I have called this a case of "Pulsating Tumour of the Orbit" because its exact nature seems somewhat doubtful. At first the symptoms pointed to aneurism of the ophthalmic artery at its origin from the internal carotid, but as time passed, and the left eye-ball became protruded, the condition seemed to be that of Aneurismal Varix—a communication between the internal carotid artery and the cavernous sinus. It may be that another aneurism has formed—this time of the *left* ophthalmic artery. But the engorgement of the ophthalmic vein and its branches, and the presence of so much chemosis, would point more to the supposition that the left orbit and eye-ball have become affected by the passage of arterial blood from the cavernous sinus on one side, through the circular sinus, into the opposite cavernous sinus and ophthalmic vein.

The Epistaxis, to a certain extent, has been beneficial, acting, perhaps, as a safety valve; but it may be that ruptures of small veins, and of the probably atheromatous nasal branches of the internal maxillary artery supplying the mucous membrane of the nose, have caused so many bleedings. The actual presence of atheroma cannot be detected in any of the arteries. Only a *post-mortem* examination will reveal the true state of matters.

Fortunately for the prolongation of life, and the carrying out, to a certain extent, of the plan of treatment, the circumstances of the patient allow of every care to be taken, although, as I have mentioned, the absolute rest that is desired cannot be obtained. It will be interesting to watch the progress of the case and its termination, which, if possible, will be duly reported.

PROCEEDINGS OF SOCIETIES.

THE NORTH QUEENSLAND MEDICAL SOCIETY.

A MEETING of medical men, called for the purpose of forming a medical Society, was held at Townsville, on January 6th. Present:—Drs. Ahearne, Clatworthy, Humphry, Nisbet, Spark, Van Someren, and Bacot:—

Proposed by Dr. SPARK, seconded by Dr. HUMPHRY—"That Dr. Ahearne be put in the chair." Carried. Minutes of the previous meeting read and adopted.

Replies to letters from Dr. van Someren to various medical men in North Queensland put in.

Dr. CLATWORTHY proposed, and Dr. VAN SOMEREN seconded—"That the correspondence be received and accepted."

Proposed, as an amendment, by Dr. NISBET—"That the correspondence as read be received." Seconded by Dr. SPARK. Lost. Original motion carried.

Proposed by Dr. VAN SOMEREN, seconded by Dr. HUMPHRY—"That the proposed Society be called 'The North Queensland Medical Society.'" Carried.

Proposed by Dr. HUMPHRY, seconded by Dr. VAN SOMEREN—"That the objects of the Society should be (1) the reading and discussion of papers and accounts, verbal or otherwise, of cases in practice, and the consideration thereof, and (2) for the promotion of the general interests of the profession." Carried.

Proposed by Dr. SPARK, seconded by Dr. VAN SOMEREN—"That the meetings of the Society be held alternately at Charters Towers and Townsville every three months, and that the annual meeting be held in Townsville at the time of the Encampment; the date of the meeting to be indicated one month previously."

Amendment proposed by Dr. NISBET—"That the meetings be held once a month, every third meeting to be held at Charters Towers, and that no meetings be held during the months of December, January, and February." Lost for want of a seconder. Original motion carried.

Proposed by Dr. HUMPHRY, seconded by Dr. CLATWORTHY—"That all those present, and those who have signified approval, be original members." Carried.

Proposed by Dr. VAN SOMEREN, seconded by Dr. SPARK—"That every legally qualified practitioner be eligible for election to the Society, such election to be by ballot."

Amendment proposed by Dr. CLATWORTHY, seconded by Dr. NISBET—"That the consideration of the words after 'such' in the above motion be held over to the next meeting." Carried.

Proposed by Dr. NISBET, seconded by Dr. SPARK—"That town members,—i.e., those residing in Townsville or Charters Towers—to pay an annual subscription of £1 ls., country members a subscription of 10s. 6d.; entrance fee for all members, 10s. 6d." Carried.

Proposed by Dr. NISBET, seconded by Dr. HUMPHRY—"That the officers should be a President, two Vice-Presidents, a Secretary and Treasurer combined, and a Council of five members with the office-bearers; office-bearers to be *ex officio* members of the Council; Council meetings to be held as required, and three to form a quorum; all offices to be annual, the outgoing officers to be eligible for re-election." Carried.

Proposed by Dr. NISBET, seconded by Dr. VAN SOMEREN—"That the Secretary be requested to send voting papers to all members in time for return before the next quarterly meeting." Carried.

Proposed by Dr. SPARK, seconded by Dr. HUMPHRY—"That Dr. Ahearne be nominated as President."

Proposed by Dr. NISBET, seconded by Dr. CLATWORTHY—"That Dr. Graham Browne, of Charters Towers, be nominated Vice-President."

Proposed by Dr. NISBET, seconded by Dr. VAN SOMEREN—"That Dr. Spark be nominated as Vice-President."

Proposed by Dr. VAN SOMEREN, seconded by Dr. NISBET—"That Drs. Kortum (Cooktown), Cuthbert (Ravenswood), Humphry, Nisbet (Townsville), and Forbes (Charters Towers), be nominated for Council."

Proposed by Dr. SPARK, seconded by Dr. HUMPHRY—"That Drs. Nisbet, Humphry, Clatworthy, Paoli (Charters Towers), and Cuthbert be nominated for the Council."

Proposed by Dr. HUMPHRY, seconded by Dr. VAN SOMEREN—"That Drs. Bowkett (Herberton), White (Geraldton), and Hunt (Hughenden), be nominated for the Council."

Proposed by Dr. SPARK, seconded by Dr. HUMPHRY—"That Dr. van Someren be Secretary and Treasurer."

Proposed by Dr. NISBET, and seconded by Dr. VAN SOMEREN—"That time and place of next meeting be notified by the Secretary and left to his discretion."

THE N.S.W. CREMATION SOCIETY.

A GENERAL meeting of the New South Wales Cremation Society, to which all ladies and gentlemen interested were, by advertisement, cordially invited, was held on January 20, at the Royal Society's Rooms, Sydney. The Hon. J. M. Creed, M.L.C., was voted to the chair. Copies of rules drafted at a previous meeting were placed in the hands of those present.

The CHAIRMAN, in opening the proceedings, said several gentlemen had written letters expressive of sympathy with the cause. He would not read all of them, but would select one from a gentleman of very high standing, namely, the Lieutenant-Governor, Sir Alfred Stephen, C.B., G.C.M.G. After speaking of the extra duties which he now had to discharge, and asking that his absence from the meeting should be excused, his Excellency wrote: "If it will in any degree be of service to the cause which you so ably advocate to say that I am entirely with you in its support, pray give that assurance for me. It is, in my opinion, impossible to doubt, after reading the views of medical men and other scientists on the subject of earth burials, and the facts which are known to exist in reference to them, that interments in churchyards in or near to populous places are sources of great danger to the public health; and that if a change can decorously be effected it is a matter of deep importance that efforts should be made to attain the object. I shall, as a public duty, become a member of and subscriber to the society, and I hope that success may attend its efforts." The chairman, in continuation, stated that among those who had also forwarded letters of approval were the Medical Adviser to the Government (Dr. Manning), Dr. Jenkins, and the Hon. D. Buchanan, M.L.C. He might add that the Hon. Dr. Garran had expressed his desire to join the society. He thought, as chairman of the meeting, that it would not be out of place if he were to say a few words as to the object of the society and its scope in the future. He said that the object of the society which had been formed, the rules for the government of which had been submitted to those present, was to press upon public attention the sanitary advantages which would attend the adoption of cremation as means for the disposal of the dead. These could best be brought about by the distribution of literature pertinent

to the subject, the delivery of lectures, meetings and discussion by persons interested, and the collection and publication of facts showing the dangers to health which were created and perpetuated by the system of burial now adopted. It was in the latter portion of its suggested duties that the society would probably render the most direct public service, for its aim would be to so strictly investigate reports of alleged sanitary neglect in cemeteries as to never lay itself open to a charge of exaggeration, so that any report from its officers to the Government would be accepted as of so much importance and urgency as to bring about immediate rectification of the reported abuse. In this way not only would it be fulfilling its mission in bringing forward additional proofs of the advantages of cremation, and by so doing increase the number of the advocates and adherents of such a system, but it would tend to lessen the evils under which the people suffer, as a consequence of the neglect of proper sanitary precautions by those people whose prejudices still made them prefer burial. The evidence in favour of the sanitary advantages of cremation were so overwhelming that, were it a matter which could be dealt with from the standpoint of reason alone, the task the society had before it would be but a light one. This, however, was not the case, for, in the disposal of the dead, sentiment and custom were perhaps more potent than in the conduct of any other human necessity. This feeling, averse to departure from a custom of centuries, was so strong that many persons whose reason convinced them that the incineration of their deceased friends was obviously the most desirable, were yet unable to brace themselves up to adopting it. No stronger example can perhaps be quoted than the Dean of the Faculty of Medicine in the Sydney University, who, in the discussion on a paper on cremation by Mr. Rusden, read at the Congress for the Advancement of Science, which lately sat in Melbourne, said that though his intellect convinced him that it was unquestionably the more preferable, yet he found it difficult to overcome the old-time prejudice in favour of burial with which he, with most others, had become imbued. He would here call attention to Rule 11, which had been formulated to meet such instances. It was thought well to place on record a statement that the association fully recognised the difficult position in which many individuals might be placed whose reason fully convinced them of advantages which would attend the success of the object of the society, yet whose feelings might render it excessively painful to them to practically carry out in the cases of lost loved ones what their intelligence induced them to think was really best. It was in meeting such cases that this society would be so especially useful, by familiarizing people generally with the revived idea, for it was no new one, being but the revival of a custom of many of the most enlightened nations of ancient times. The mission of the society was a purely sanitary one, and it felt that in the conduct of its work it must confine itself to this reason. It desired to press upon everyone that even if the subject had a religious aspect the association would exclude it from its work. It felt that people of all shades of belief could meet upon common ground, and that no form of faith necessarily excluded its followers from cordial co-operation. The ordinary religious ceremonies of all faiths could as well be carried out when a body was disposed of by cremation as by burial, and the crematorium must be a perfectly neutral ground, common to all. Sentiment, which was so strong a factor in favour of the continuance of any long-established custom, was especially strong in the disposal of the dead, because it arose from that loving respect with which all regarded the remains of deceased

friends. It was, however, no stronger with those in these colonies than with nations of antiquity, whose customs in this direction, though very different to ours, were clung to with equal if not greater tenacity. The object of all had been to perpetuate the memory of the deceased and to preserve the remains from disrespect. Probably no race took greater trouble or went to greater expense with this object than the ancient Egyptians; but with what result? It was found that their most venerated dead were regarded as mere scientific curiosities, the more fortunately-fated of which were, perhaps, carefully preserved in great museums, whilst others, the remains of men of equal virtue, were among the attractions of vulgar shows, carted from town to town, until, by being tossed from side to side, they became too fragmentary to aid in bringing shillings to their proprietors, who had purchased them for a few pounds. No instance of this character could be quoted which should have greater effect on British feeling than that conveyed in the statement, believed to be true, that the head of that greatest of Englishmen—Oliver Cromwell—was still preserved as a curiosity by a family in England. How frequently, he asked, did the exigency of public improvement necessitate the removal of a cemetery, when the major portion of the remains, on removal, became so mixed as to be treated as so much rubbish to be shot into the nearest convenient depository? This had already happened in this young city, and they all knew must and would again occur in the near future. Had cremation been the custom adopted in each of these instances the disrespect he had instanced could never have occurred. However great the precautions that might have been taken for the preservation of the sanctity with which it was desired to surround the depositories of deceased humanity, sooner or later they were broken down; it might be in twenty, or it might be in a thousand years, but happen it would. Cremation so quickly reduces the body to its original elements that such possibility of desecration was minimized by its adoption, for at the worst it but meant the distribution of a small quantity of amorphous ashes in the surrounding earth. In older countries there was urgent necessity for some means of disposal of the dead which would avoid the creation of such masses of decaying animal matter, poisoning the surrounding air and water, as their cemeteries now were. A recent official return as to the condition of the London cemeteries was a very unsavoury revelation. It was stated in it that during the last 50 years 155,064 bodies had been deposited in the Brompton Cemetery, with an area of less than 29 acres, and that during the same time in the Tower Hamlets Cemetery, which was only 17 acres in extent, 247,000 bodies had been buried. When it was remembered that these masses of animal corruption were situated in the midst of a dense population the fact became horrible to contemplate. They had evidence of the neglect of due precaution in the sanitary management of the cemeteries near their own city in the reports of Dr. Ashburton Thompson to the Board of Health on the condition of the Balmain cemetery, and of some graves at the Necropolis at Rookwood. In such a brief address it was impossible to hope to do more than to induce more extended inquiry and thought as to the existing evils, and as to the merits of cremation as a means of remedying them. (Cheers.)

The gentlemen present having enrolled themselves either as members or associates of the society, according to the views they entertained,

Mr. R. P. RICHARDSON, J.P., moved that the following officers be elected for the current year:—President, the Hon. J. M. Creed; vice-presidents, the Hon. A.

Garran and Mr. Edward Greville, J.P.; hon. treasurer, Mr. D. Vernon; committee, Drs. R. E. Roth and E. J. Jenkins, and Messrs. W. J. Green, J. W. Hill, R. P. Richardson and John Plummer. The whole to form the council.

Mr. W. J. GREEN seconded the resolution.

Mr. D. MATTHEWS, in supporting the resolution, said that the old practice of disposing of the dead was one which had served its purpose, but ought now to be done away with. Still, in his opinion, the progress of the society would be slow, though sure. From personal observation and inquiries he was convinced that in England cremation was growing in favour.

The resolution, on being put, was unanimously carried.

The CHAIRMAN, in conclusion, thanked those present for their attendance, and invited them to introduce the subject to their friends. It was not simply money that was wanted, but the names of persons who were willing to become associates. The time might come when the society would have to press the Government on this matter, and in that case the number of names available would be a matter of great importance. If cremation were to come into general use here the cost of incineration should not amount to more than 20s. per body.

A vote of thanks to the chairman closed the proceedings.

MEDICAL APPOINTMENTS.

- Bradford, William Arthur, M.B. & Ch.M. Glas., to be Public Vaccinator for Dartmoor, Vic.
 Christian, John, M.R.C.S.E., to be acting Government Medical and Health Officer at Port Douglas, Qu.
 Duff, John, M.D. & Ch. M. Qu Univ. Ont., M.C.P.S. Ont., L.R.C.P. & R.C.S. Edin., L.F.P.S. Glas., to be Public Vaccinator for Harrow, also Health Officer for Kowree Shire, Vic.
 Fisher, Thomas Carson, A.B. M.D., M.Ch. T.C., Dubl., appointed an Honorary Surgeon of the Berrima District Hospital, Bowral, N.S.W., vice Dr. L. G. Davidson, resigned.
 Johnston, John, M.B. & Ch.M. Glas., to be Public Vaccinator for Williamstown, Vic., also Certifying Medical Officer under the Factories and Shops Act, 1886.
 Lempriere, Charles Louis, M.B. & Ch.M. Edin., to be Public Vaccinator for South Yarra, Vic.
 McLennan, Warwick Guy, L.R.O.P. Ed., M.R.C.S.E., to be Public Vaccinator for the District of Pahiatua, N.Z.
 McNaughton, John, M.B. & Ch.M. Edin., to be Public Vaccinator for Minyip, Vic.
 Money Percy Frederick, M.R.C.S.E., L.R.C.P. Ed., to be a Public Vaccinator for the District of Buller, N.Z.
 Newman, Fossey James, M.B. & Ch.B. Melb., to be Public Vaccinator for Geelong, Vic.
 Pairman, Robert, M.D. & Ch.M. Ed., to be Public Vaccinator for the District of Opunake, N.Z.
 Parkinson, Charles Joseph, M.B. Lond., M.R.C.S.E., to be Health Officer for Shire of Malvern, Vic., vice Dr. J. A. Irwin, resigned.
 Percival, Montague William Cairns, M.K.Q.C.P. Irel., to be Public Vaccinator for Surrey Hills and Doncaster, Vic., vice Dr. W. H. Stock, resigned.
 Praeger, Lionel Francis, M.B. & Ch.B. Melb., to be Public Vaccinator at East Melbourne, Vic.
 Sturt, Clifton, L.R.C.P. & R.C.S. Ed., L.F.P.S. Glas., to be Government Medical Officer and Vaccinator for the District of Bull and Coal Cliff, N.S.W.
 Watkins, Sidney Collins, M.R.C.S.E., to be Government Medical Officer and Public Vaccinator for the District of Manly and Pittwater, N.S.W.
 Wilson, Samuel, M.D. & Ch.M. Roy. Univ. Irel., L.K.Q.C.P. Irel., to be Public Vaccinator for Shire of Philip Island, Vic.

GENUINE PRACTICE, with good house, wanted by cash purchaser; state particulars and premium required. Address Surgeon, care of L. Bruck, 13 Castlereagh-street, Sydney.

NOTICE.

The Editor will feel obliged by any gentleman, who wishes to ventilate any subject of professional or public interest, writing an editorial or leading article on it, which if found on perusal to be consonant with the policy of the paper, will be inserted in an early number.

All communications intended for the Editor should be sent to the 'A. M. Gazette' Office, 35 Castlereagh Street, Sydney.

*** Contributors can have their Papers reprinted and published in Pamphlet form, at Cost Price, if the necessary instructions are given to the Publisher at the same time the contributions are sent in.*

AUSTRALASIAN MEDICAL GAZETTE.

SYDNEY, FEBRUARY 15, 1890.

EDITORIALS.

THE NEW SOUTH WALES CREMATION SOCIETY.

SINCE our last issue a society has been established in Sydney whose object is to disseminate information as to the evils which arise from the present system of earth burial and the consequent advantages which would follow the adoption of cremation in its stead.

The subject is one which, if it could be left to reason for decision, would quickly be settled, for though it may be said with some truth that a properly managed cemetery in a sparsely populated district is little likely to give rise to serious sanitary evils, yet it cannot be denied that even this risk would be removed by the disposal of the bodies by fire. That a single body, when buried, may be the source of very grave danger to the living is shown by the researches of Dr. Friere, of Rio Janeiro, into the etiology of yellow fever. These showed that the soil surrounding a body buried after death from that disease became impregnated with its specific germs, and that the disease has been reproduced by water contaminated with such earth.

It is not argued by the society that cremation is so urgently called for in this new country as it

is in those more densely populated, but it does feel it to be its duty to so educate public opinion that unreasoning and illogical prejudices shall not be allowed to override good and sufficient reason which may arise for this great sanitary advance. No one expects that it will be at once adopted even by many of the persons whose reason and intelligence have induced them to join the society and to add their influence towards ultimate acceptance of the revived method. All objectors give as their reason that they think that the burning of the body savours of disrespect to their deceased friend, and is destructive of that sentiment with which they would surround it during the last moments they have it with them. Intelligent thought, however, must convince every unprejudiced person that it is more consonant, both with respect and sentiment, to quickly bring about the resolution to its original elements of the body of a dearly loved friend by the cleanly and effective process of burning than by putting it in a box, into the earth to remain a festering, worm-eaten, disgusting mass of corruption for months—so loathsome an object that the most devoted love would shrink from sight, smell or contact with the horrible thing it had become. The society is making good progress, and though its special mission is to direct and educate public thought in what it believes to be the right direction, it will as quickly as possible do its best to provide the necessary means for giving practical effect to its object.

We have recently received a communication, signed by the Duke of Westminster on behalf of the Church of England Burial Reform Association of Great Britain, this, on the personal knowledge of the writer, gives appalling instances of the evils consequent on the present system of burial, dwelling especially on the fearfully overcrowded state of cemeteries, and very properly condemning the use of substantial and slowly perishable coffins. So far we agree, but regret to find that, having indubitably proved the necessity for the adoption of cremation, His Grace throws his influence in favour of the continuance of earth burial with fragile and easily perishable coffins.

By such means, no doubt, the period of danger consequent on mere putrefaction is lessened, but what about the disease germs, that are thus more quickly and thoroughly mixed with the surrounding soil, and which retain their vitality and power of evil for many years, as has been shown by the researches of Pasteur, Domingo Friere, and by instances given by Sir Spencer Wells and others of the reappearance of specific diseases on the disturbance of the ground containing the graves of persons who had died of it many years before.

THE NORTH QUEENSLAND MEDICAL SOCIETY.

THE rapid advance that is being made in the settlement of Australia is very forcibly shown by the foundation of a Medical Society in Northern Queensland, the meetings of which are to be held quarterly at Townsville and Charters Towers alternately, and the annual meeting is to be held at Townsville. The new society is, we are informed, receiving the almost unanimous support of the medical men in the north, and it must be of service not only to its members, but to the public of that portion of Australia. We say this because it is an infinite gain to the patients that their medical attendants should by social intercourse and conversation with their professional brethren keep themselves abreast of the times in all advances of medicine. No doubt this can be done by reading, but much more effectively by discussion such as is brought about by the meetings of these societies. The district, of which this society will be the professional centre, is situated entirely in the tropics, where there are doubtless in a new country fresh types of disease calling for accurate observation which will be promoted by such an association. As an example of the progress of these districts we may add that when we visited Townsville there was no medical man in Australia north of Bowen, whilst now medical practitioners are so numerous as to lead to the foundation of a Medical Society.

THE NEW CENTRAL BOARD OF HEALTH OF VICTORIA.

THE new Central Board of Health in Victoria, as elected under the recently passed Health Act of that colony, is for the purpose for which it has been called into existence a remarkable body. Of its nine members but one is a medical man, Dr. Gresswell, and he is new to Australia, in fact has not yet arrived here. The other members are for the most part shire-councilmen or aldermen, the chairman being a barrister. In commenting on his appointment, *The Argus* says that as he has been in the habit of controlling "a somewhat demonstrative Assembly—the University Senate—he should be able to keep the Board of Health under due control." It thus seems to be thought probable that there are likely to be lively times. The success or failure of a board of health is a matter of infinitely greater personal interest to the lay public than to the medical profession, except in so far as its failure will mean more disease, increased professional work and consequent profit to its members. Such a

body, composed with one exception entirely of laymen, is of so exceptional a character that we shall wait in amused expectation for the probable exhibition which it will make of its incapacity.

A CONSCIENTIOUS NEWSPAPER.

NOTICE TO ADVERTISERS.

MEDICAL ADVERTISEMENTS of a non-professional character will not be received for INSERTION in these columns.

JOHN MACLEAN,
Proprietor.

Shoalhaven Telegraph Office,
Nowra, N.S.W.

THE above advertisement is of so exceptional a character, and exhibits such unwonted but generous self-abnegation on the part of a newspaper proprietor in the public interest, that we think we should fail in our duty did we not call attention to it. This decision to exclude quack advertisements shows such a kindly regard for the welfare of the ignorant or inexperienced among the readers of the paper as cannot be too highly praised. It must not be forgotten that such advertisements are exceedingly profitable to the proprietors of the papers which insert them. They are, however, the cause of grievous trouble, both in mind, body and pocket, to the unlucky wights who are duped by them, and so induced to communicate with the scoundrels for whose profit they are inserted. Instances are almost daily brought under our notice of mental and physical distress—in many instances of a most distressing character—which have had their origin in such advertisements as the *Shoalhaven Telegraph* so conscientiously refuses to publish.

LETTERS TO THE EDITOR.

CASE OF ELEPHANTIASIS ANÆSTHETICA IN THE PALMERSTON (N.T.) HOSPITAL.

(To the Editor *A. M. Gazette*.)

SIR,—Thinking you might, perhaps, like to publish a short account of a case of Elephantiasis Anæsthetica, I send you the notes of a case that occurred under my care in the Palmerston Hospital, Port Darwin.

M. B., *ætat* 63, an American by birth, a teamster by occupation, and a resident in the Northern Territory of South Australia for upwards of thirteen years, was admitted into the hospital on October 10, 1887.

He had been under my care at various intervals for about 18 months previously. The chief symptoms being progressive weakness, together with numbness in his feet, and burning shooting pains in his feet and legs at the earlier part of the night, which he used to relieve by taking laudanum.

He said that he had suffered a good deal from venereal diseases and rheumatism, and he had contraction of the palmar fascia of the right hand, chiefly implicating when I first knew him the first finger. He had very deficient patellar reflex, and a staggering gait.

In September, 1887, he came to me stating that he had a sore on his right heel, which he only found out by noticing that his sock stuck to it, as there was no pain with it. On examining it I found the probe touched the os calcis, on account of its punctated appearance. I examined the boots and found a long nail sticking up in the heel. He had never noticed it. This was removed, and he wore a pad to relieve pressure and it began to heal. Shortly afterwards he came to me saying that he had a sore on his gluteal region which he only discovered by his trousers adhering to it. I then found out that a great part of his gluteal region was anæsthetic, and I admitted him into the hospital, diagnosing the case at that time as one of locomotor ataxy, with probably syphilitic deposits in the cord interfering with the nutrition of the skin. I placed him in bed, gave him antispecific medicines, and by the time that I handed the hospital over to Dr. Bovill on November 10 (who relieved me while I had leave of absence) the gluteal wound was well, and the heel wound looked to be drying up. The anæsthesia was no better, and more patches were found on the legs, especially over the ligamenta patellæ, and the skin over them was a trifle paler than the surrounding. The palmar fascia had contracted rather more, the nocturnal pains were not much relieved, but his appetite was very good and he said he felt better.

During my absence in England, Dr. Bovill removed a loose piece of the os calcis, and the wound then healed. The anæsthetic patches got larger and whiter. They formed on his side and his arms, large bullæ used to form on his fingers very quickly, during a night or day, and almost as rapidly dry up and heal. Nocturnal pains were unrelieved, and they occurred in his hands as well. He lost flesh, muscles began to waste, especially those of the thumb. The expression was very melancholic and his temper very irritable.

When I returned, June, 1888, Dr. Bovill suggested to me that the case was one of elephantiasis anæsthetica, and I found him in the following state. Palmar fascia had contracted more and now implicated all his fingers. His left hand remained unaffected. Healed wound quite dry; gluteal wound quite healed. The anæsthetic patches on his legs and gluteal region very extensive, a large anæsthetic patch on his right side, and several patches on his arms, and these appeared very white owing to the brown colour of his skin produced by long exposure to the tropical sun. The pains in his hands and feet were intense, and only relieved by large doses of laudanum. Nothing to be noticed about his eyes. One of them was blind owing to an injury received in his youth. After mature consideration I came to the conclusion that Dr. Bovill was correct, and we wrote a joint letter stating that we had a case of elephantiasis anæsthetica in the hospital, that had originally been admitted into the institution for an obscure nerve disease, and though we did not consider the disease contagious we thought the public did, and we requested that he might be removed to Adelaide where he could be better looked after than we could here, and because we noticed that the late Sir Erasmus Wilson, in Quain's Dictionary, urges that the first thing in treatment of this disease should be to remove the patient from the district in which the disease had been engendered.

After a lapse of nine days I received instructions from the Government authorities, stating that the Colonial

Surgeon (in Adelaide) says "that elephantiasis is not considered contagious in the East, and no good would accrue to his coming to Adelaide, and the case may be dealt with in the Territory."

The case went on, gradually getting worse. The patient gets feebler; the heel wound breaks down again; I find more loose bone and remove it, and it then heals and kept healed till within six weeks of his death. The hands continue to have the bulbous eruptions. They last about four days each crop from the time they appear until the time they are healed. When moist his hands were kept covered with antiseptic dressings.

About October a small sore occurred in his left heel. This turned out to be caused by a stone getting into his shoe and thence into his heel. It was removed and the sore quickly healed. He was then ordered to have strong canvas sown on to his socks.

He gradually got weaker and very irritable, and was put into a small room by himself on account of his bad temper. About two months before his death, in March (he died in May), a sore appeared on the sole of his left foot. This made several efforts at healing, but gradually got deeper but never quite perforated. The heel cicatrix became moist again; the pains in his feet and hands intense. The want of tone of his facial muscles made his facial expression extremely sad.

About fourteen days before death he complained that he could not read long at a time, and that black spots kept coming over his eye. I then discovered that the conjunctiva and cornea had become anæsthetic. I noticed this by seeing a fly on the conjunctiva, and only frightened away when it went across the iris. The cornea was quite opaque before death. The mucous membrane of the mouth and nose was unaffected.

About this time a sore was formed over the metatarsal phalangeal joint of right little toe. This joint was opened before death. The gluteal wound was just beginning to break down.

The last nine days he became very lethargic, then weakness of his left side, then hemiplegia, general paralysis, coma, death.

The only remarks I will make on this case—

Urine was always low in specific gravity, pale and acid, and only towards the end contained albumen. The bullæ only occurred on his fingers, and contained a thin watery fluid. The sores secreted a thin yellowish pus, and the surface of the wounds were painless and of a greenish-yellowish colour. The anæsthetic patches became whiter with age, and had absolutely no sensation in them.

The medicine that he found to give him the greatest relief was tinct. Cannabis Indicæ and Pot. Bromid. in large doses.

In conclusion, as I think that medical opinion, especially in Melbourne, is in favour of the disease being of a contagious character, may I quote from *The Lancet* of June 29, 1889:—"Another point is that of these three forms the non-tuberculated or nerve leprosy stands on a totally different footing as regards transmissibility from the tuberculated or skin leprosy and the mixed or skin and nerve form. The most strongly-convinced believers in contagion admit that the non-tuberculated leprosy is non-contagious, the ulcers being secondary to the nerve changes and not directly due to leprosy poison."

"This 'bacillus' in the non-tuberculated cases, on the other hand, is invariably absent in all the sores due to the diseased nerves, but it has been found in the nerves themselves when the disease is not of too old a

standing, as it is in those skin lesions of mixed nerve and skin leprosy. This goes far to explain the non-transmissibility of nerve leprosy."

"It is obvious therefore that isolated cases of leprosy might safely be admitted to the wards of a general hospital, the attendants only taking the same precautions against personal inoculation while dressing the sores as they would in a case of syphilis."

PERCY MOORE WOOD,

Late Govt. Med. Officer for the Northern Territory.
On board the R.M.S. "Massilia" approaching Colombo,
November 15, 1889.

THE RAPID HEALING OF WOUNDS.

(To the Editor of the A. M. Gazette).

SIR,—I have read with great pleasure the letter of Dr. Moffitt, in your issue of 15th January, and was especially struck with that portion dealing with the rapidity of the healing process of wounds from injuries and surgical operations. I, too, have noticed with pleasure and astonishment the extreme rarity of suppuration and almost general healing by first intention of wounds in the Vegetable Creek Hospital. At first I thought that it must be the general rule in Australia, but our matron, Miss Webb, who has had a large experience in Sydney Hospital, assures me that such is not the case, and that the same thing had been noticed by her since her arrival here. Two cases will exemplify this:—One was that of an elderly man with a large cystic tumor beneath the latissimus dorsi muscle, which was excised in the usual manner, and which healed completely without the appearance of any pus, the man being discharged cured in 10 days. The second case was that of an Arabian hawk, who was thrown from his horse between my residence and the hospital. I found him lying in a ditch by the roadside with the right ankle dislocated, fibula and malleolus of tibia broken, the foot completely turned over so that the sole was directed upwards, and the articular surface of tibia exposed and covered with fine sandy gravel. A stretcher was brought from the hospital, the man removed thither, the wound carefully cleansed, dislocation reduced, the whole dressed with iodoform, and bandaged to an inside splint with carbolic gauze bandage. No untoward symptom of any kind took place, there was no suppuration, the only discharge being that of a slightly sanguinolent fluid for the first few days, and the man made an uninterrupted recovery. So far, Emmaville and Broken Hill appear to be equally desirable from a Surgical point of view; but I cannot attribute the cause to the *dryness* of the air in the case of the former district, for during the time the second patient was undergoing treatment the weather was exceptionally wet and stormy. The elevation of Emmaville is a little over 3000 ft., a mountainous district, well covered with bush and sparsely populated. May not these combined influences, together with the advantage of a well-ventilated hospital, and strict cleanliness be the factors engaged in attaining so desirable a result?

I am, &c.,

L. DAVENPORT PARRY,

Medical Officer,

Vegetable Creek District Hospital.

Emmaville, N.S.W., January 28.

CASE OF SNAKE-BITE CURED BY STRYCHNINE

(To the Editor of the A.M. Gazette.)

SIR.—As Dr. Mueller, of Yaokandandah (Vic.), in the *Gazette* desires that cases of snake-bite cured by strychnine should be recorded I send you a case which occurred here and was successfully treated with that remedy.

A powerful young man was bitten in the right calf by a large black snake at 3.30 p.m. The part was immediately freely incised, ligature applied about 15 minutes later, and he was freely dosed with brandy and ammonia.

I was unfortunately absent on being called, and did not get to him till 7.15 p.m. He was then collapsed and cyanosed. A subcutaneous injection of Liq. strychninæ B. P. $\text{m} \times \text{v}$ had immediate effect. He walked firmly and showed the effects of the brandy by becoming very quarrelsome. The influence of the snake-poison returned three times, namely, at 8.15, 9.0 and 10.0 p.m., on which I injected respectively $\text{m} \times \text{viii}$, and $\text{m} \times \text{vii}$. From the administration of the last dose he steadily improved, and at 1 a.m. I dismissed him cured and in his right mind.

He complained afterwards of some pain and swelling in the left arm where the injections were effected, and at the wound, both of which soon disappeared.

I am, sir,

Yours truly,

FRANCIS PAIN, M.R.C.S., etc.

Allora, Queensland,
January.

MEDICAL LEGISLATION IN SOUTH AUSTRALIA.

(To the Editor A.M. Gazette.)

DEAR SIR,—I see by the last number of your journal that South Australia has passed a new Medical Bill. I am very sorry, for, though doubtless an improvement on the old Act, it is sadly deficient; and, also, I regret the passing because I have been for some little time trying to initiate colonial federation in the way of Medical Acts, my idea being that, as all the Australian colonies want either new Acts or old ones amended, that we should arrange for each colony to send a delegate or delegates to some central place of meeting who would then agree, after discussion, to adopt one uniform Medical Bill for all the colonies. If this were done no Legislative Assembly would refuse to pass it; in fact, we could bring such combined pressure to bear that the various Ministries would feel it their duty to give their support to the Act. You saw the Bill that I had the honor to draft by request of Queensland Medical Board and Societies, and I was gratified by your approval. It did not come before our Assembly on account of want of time, caused by the deadlock. If my scheme could be carried out I hope that, in spite of their new Bill, South Australia will join. Please give this your earnest attention and help if you approve.

I remain, your obedient servant,

S. MATTHEWS OWENS.

Queensland Club,
Brisbane, January 29.

[We fear our correspondent is somewhat sanguine in his idea that a Medical Act could be so easily and simultaneously passed in all the colonies. However, let him continue to devote himself to what we all must admit is a worthy object.—Ed. A.M.G.]

A QUESTION OF MEDICAL ETIQUETTE.

(To the Editor of the A. M. Gazette.)

DEAR SIR,—Would you kindly give me your opinion on the following: A practitioner, who lives in a suburb about three miles up the line from here, takes a run to the country; he is engaged to attend a lady in her confinement; he leaves on Saturday, January 20th, and on the Tuesday morning, about half-past 2, I received a call to attend the lady, as she was in labour. I immediately went and attended the lady in her confinement, also the usual nine days. The medical gentleman never asked me to attend for him in his absence, but wrote a letter to the husband saying he was leaving town, and if his wife was taken ill to send for Dr. Clune. The husband called on me the night (Saturday) he received the letter from the doctor, and showed me the letter. I told him I would attend, and consequently did attend.

I would like to know from you if I am entitled to the full fee of five guineas, which I intend to charge. The doctor did not say how long he would be away. I told the husband to write to the medical man, telling him that I attended the case, and asking him to take it up. He did not receive any answer from him; but I received a letter from the medical gentleman to-day, stating that when I was paid the fee for the Mrs. So-and-so accouchment, would I kindly send him half. Waiting for a favourable reply,

I remain,

Yours truly,

ETIQUETTE.

February 1st, 1890.

[Under the circumstances detailed above we are of opinion that the medical man originally engaged to attend will have no just cause of complaint if our correspondent declines to hand over half the fee, the whole of which he has fairly earned. To have a just claim to a moiety of the fee the practitioner originally engaged should not have neglected the courtesy of communicating with the accoucheur whom he suggested as his substitute, and have requested him to attend on his behalf.—ED. A.M.G.]

AN ALLEGED SPECIFIC FOR DIPHTHERIA.

(The Editor A.M.G.)

DEAR SIR,—The enclosed communication might, perhaps, be of interest to your readers, and if any of them wish to form "a syndicate" upon the very liberal terms which the owner of the specific has offered, why then they are heartily welcome to my share without fee and the whole of the honour.

Yours truly,

F. W. ELSNER.

Richmond (Melbourne),
January 22, 1890.

Church-street, Bega, New South Wales, January 13th, 1890. Bega House, Henry O. T. Cowdroy, General Merchant. Wholesale Department, Centennial Buildings. Millinery, Dressmaking, Drapery, Boots and Shoes, Fancy Goods, Reliable Groceries. Vans deliver daily.

DOCTOR ELSNER,

Sir,—I notice your letter to the *A. M. Gazette* in which you condemn steam as a remedy for Diphtheria. I therefore write you to say you can add something to the steam, which, in conjunction with a Powder that I know off is an *effectual cure*.

I may state that my cure is within the reach of everybody, and I am prepared to come to terms with any Medical Man for its use. I don't want any pay until it is tried when on proving its success I want £500.

If you think it worth while you can write me.

The above address will find yours faithfully,

H. O. T. COWDROY.

[We fear Mr. Cowdroy will have to stick to boots and shoes, drapery and groceries, &c, as a source of profit. We may, however, call attention to the fact that medical men, when they believe they have discovered a new remedy publish it, with the data upon which they found their belief in its efficacy, for the information of their professional brethren, so that if it really be an advance in treatment all sick people may reap the benefit. It is only the commercial mind of the benevolent layman which desires to make the possession of a secret for the cure of disease a source of personal profit. We hope, however, that the philanthropic Mr. Cowdroy will not labour under the delusion that we think it likely that his remedy is of the slightest novelty or value.—ED. A.M.G.]

BOOK NOTICES.

DISEASES OF WOMEN. A Manual of Non-Surgical Gynecology, designed especially for the Use of Students and General Practitioners. By F. H. Davenport, A.B., M.D., Assistant in Gynecology, Harvard Medical School; Assistant Surgeon to the Free Hospital for Women; Physician to the Department of Gynecology, Boston Dispensary. With 105 illustrations. Philadelphia: Lea Bros. and Co., 1889. Sydney: L. Bruck (Price, 7s. 6d.).

The absence of practical details and minor points of gynecological manipulations in the standard text-books has induced the author to offer this work as a means by which the deficiency may be supplied. The methods of examination, the diagnostic significance of signs and symptoms, and the mode of treatment of the more common forms of pelvic disease, as well as the general principles on which the gynecological art is based, are treated in a clear, detailed, practical fashion, supplying to the non-specialist what experts have learned from experience. Especially his chapter on "Displacements of the Uterus," which includes the methods of diagnosis, the use of the probe, and the instructions for measuring the vagina and applying pessaries, would do credit to a very much larger and more pretentious treatise. The work has, in our opinion, been done in a satisfactory manner, and we have no doubt will be appreciated by those for whom it is intended.

PULMONARY TUBERCULOSIS: ITS ETIOLOGY, SYMPTOMATOLOGY AND THERAPEUTICS. By Prof. Dr. H. von Ziemssen, Director of the Medical Clinic at Munich. Translated by David J. Doherty, M.D. Detroit: George S. Davis. Sydney: L. Bruck (Price, 4s. 6d.).

This work represents the views on tuberculosis of one of the most eminent of German clinicians, and deals with the etiology, diagnosis and treatment of that disease. The first part, devoted to the etiology of tuberculosis, is an intelligible digest of modern theories, the necessary consequence of the classical research of Koch. In the second part special features in the symptomatology are considered. Great importance is attached to the percussion of the apices; any difference

in the height to which they rise above the clavicles between the two sides being regarded as one of the early signs of pulmonary tuberculosis. The third part is devoted to the treatment of the disease under consideration, which the author divides into prophylactic, hygienic, dietetic, medicinal and climatic. The latter is, however, one of the most potent factors, and observations are adduced in support of this view. There is also an appendix by the translator, containing a table of tuberculosis in American prisons, showing the percentage of deaths from phthisis, as well as a method of examining sputum for tubercle bacilli.

GYNECOLOGICAL ELECTRO-THERAPEUTICS. By H. R. Bigelow, M.D. With an introduction by Dr. Georges Apostoli. Illustrated. London: H. K. Lewis, 1889. Sydney: L. Bruck (Price, 8s. 6d.).

The merit of this book consists in the fact that it presents in a convenient form the substance of Apostoli's teaching on the subject of gynecological electrotherapeutics. In view of the great interest which is now felt in this subject the book is very timely. In spite of Apostoli's success and the wide-spread knowledge of his methods the use of electricity, as he recommends it, has not become as yet by any means general. This may be due partly to the expense of the apparatus, and partly to the fact that the more brilliant if less safe results by operative measures have proved more attractive to the surgeon. The increased knowledge of the methods of Apostoli, which this book will bring within easy reach of every gynecologist, will undoubtedly result in a more wide-spread use of this agent. Dr. Bigelow is to be congratulated upon presenting to the profession in so attractive and satisfactory a form the important facts with regard to this agent, and its application, by the acknowledged leader in its use.

ON THE TREATMENT OF THE MORPHINE HABIT. By Dr. Albrecht Erlenmeyer. Translated from the German. Detroit: Geo. S. Davis, 1889. Sydney: L. Bruck (Price, 4s. 6d.).

The difficulty of properly treating the morphine habit has led to the devising of many methods, the introduction of many so-called antidotes, and the founding of many institutions. Probably no author is better prepared to advise on the subject than is Prof. Erlenmeyer. The author prefers the "rapid" method of removing the drug from the patient, as contradistinguished from the "sudden" and the "gradual." The greater part of the treatment, and the more important part, is that of the period of convalescence. The entire course, according to his method, requires six weeks. The translator tells us that "the aim of this little volume, in fact, is to give a plain, concise, and practical presentation of the therapy of morphinism, according to Erlenmeyer's teachings." A chapter is included, which gives his method of treating the cocaine habit.

THE URINE, THE COMMON POISONS, AND THE MILK MEMORANDA, CHEMICAL AND MICROSCOPICAL FOR LABORATORY USE. By J. W. Holland, M.D. Illustrated. Third edition. Revised and much enlarged. Philadelphia: P. Blakiston, Son & Co., 1889. Sydney: L. Bruck (Price, 4s. 6d.).

As a pocket volume for ready reference and for use in the laboratory the student will find the work invaluable. The author gives: 1st, The composition of healthy urine; 2nd, Examination of morbid urine; 3rd, Examination of common poisons, and lastly, a study of normal milk. Every alternate page is left blank for calculations and memoranda. The more im-

portant matter is printed in larger type, while the explanations and quantitative processes are given in the smaller print. The book is well adapted to its use, as is shown by the rapidity of its editions. The union of the subjects considered is a happy one, giving the book importance to the practitioner as well as to the student.

THE MONTH.

NEW SOUTH WALES.

At a meeting of the newly-formed New South Wales Cremation Society, held at the Royal Society's Rooms, Sydney, on January 20, the following officers were elected:—President, the Hon. J. M. Creed, M.L.C.; Vice-Presidents, the Hon. A. Garran, LL.D., M.L.C., and Edward Greville, J.P.; Honorary Treasurer, Mr. D. Vernon; Committee, Drs. R. E. Roth and E. J. Jenkins, and Messrs. John Plummer, W. J. Green, J. W. Hill and R. P. Richardson, J.P.

THE officers of the Board of Health at Watson's Bay and Newcastle were ordered last month to inspect all vessels arriving from ports in Europe where the influenza epidemic has been raging.

THERE are 13 persons known to be suffering from leprosy in New South Wales who are detained for isolation and treatment in a portion of the Coast Hospital at Little Bay, near Sydney. The lepers are ten Chinese, one Javanese, and two natives of New South Wales of European parentage.

178 patients were treated at the Balmain Cottage Hospital during the past year.

At the Balranald Hospital during the past year 107 in-patients were treated, 80 cases were cured, 7 relieved, 1 sent to the Benevolent Asylum, 13 died, and 6 remained in the hospital. There were also treated 73 out-patients.

At the committee meeting of the Bathurst Hospital, held on January 20, Mr. W. H. Paul, M.L.A., brought forward a resolution declaring that the recently-appointed medical officer should either resign or receive the necessary notice that his services were no longer required. At a previous meeting the honorary medical officers had resigned, and at the present meeting the resignation of the matron and nurses was received, who declared that it was impossible to work with the resident medical officer. After a long argument and a considerable exhibition of feeling, Mr. Paul's motion was negatived by 10 to 9. The resident medical officer afterwards sent in his resignation.

THE number of in-patients at the Forbes Hospital during the year 1889 was 156, and out-patients numbered over 200. A sum of £145 was received from paying patients. During last year 3,455 beds were occupied, giving an average of over 10 per diem. The death rate for the year was only 4.5.

At the Goulburn Hospital 134 patients were treated during the year, 83 being cured and 33 relieved, while 18 died.

At the Grafton Hospital during the past year 119 patients were treated, of whom 64 were cured, 30 were relieved, and 8 died; 22 were cases of accidents and 90 disease. Besides these, 18 outdoor patients received relief.

DURING the past year there had been 37 patients under treatment at the Kiama Hospital, three of whom had died. The total number of patients admitted for

treatment since the opening of the hospital about three years ago was 106.

At the Nymagee Hospital 48 patients were treated during the past year, of whom 47 were discharged cured and one died.

At the Orange Hospital the number of patients admitted during the year was 158, of whom 129 were discharged and 25 died. Drs. Proudfoot and Codrington have been elected surgeons for the current year out of four applications.

FIFTY-FOUR patients were admitted to the Parkes District Hospital in 1889; 35 of these were cured, 6 relieved, 8 died, and 5 remained in the hospital on December 31.

DURING the year 222 patients were treated at Parramatta district hospital; 167 were discharged cured, 44 relieved, and 24 died. The average number of patients kept in the hospital was 25.7.

THE number of patients admitted to the Wagga Wagga Hospital during the past year was 196.

DURING the past year 126 cases were treated at the Wilcannia Hospital, of which 80 had been cured, 29 relieved, nine died and eight remained in the hospital on December 31. There had also been 108 treated as out-patients. The daily average of in-patients was eight.

DR. W. G. ARMSTRONG, of Merriwa, has been appointed a Magistrate for the colony.

DR. R. BEITH, late Government Medical Officer at Fiji, has succeeded to the practice of Dr. A. Barber, in Mudgee.

DR. W. BOAKE has been unanimously elected Medical Officer of the Grenfell Hospital.

DR. T. CARSON FISHER, late of the Sydney Hospital, has succeeded to the practice of Dr. L. G. Davidson, at Bowral.

DR. W. HEINEMANN has resumed practice at Orange.

DR. W. L. MATHIAS, a new arrival, has commenced practice at 69 Darlinghurst-road, Sydney, in conjunction with Dr. B. Kyngdon.

DR. C. W. MORGAN has resumed practice at Newcastle.

DR. M. J. O'CONNOR, of Sydney, has been appointed a member of the Medical Board of New South Wales, in the place of Dr. Evans, deceased.

DR. J. J. G. MURRAY has been re-elected Medical Officer to the Parkes District Hospital by 85 votes, while the other applicant (Dr. Eagar) secured only 14 votes.

DR. JAS. T. WILSON, Demonstrator of Anatomy at the Sydney University, has been appointed to the Challis Chair of Anatomy.

NEW ZEALAND.

At Wellington, last month, a banquet was tendered to the Hon. Dr. M. S. Grace, M.L.C., in celebration of his having been raised to the dignity of a Count of the Holy Roman Empire.

DR. W. W. CHRISTIE, late of the Belvidere Fever Hospital in Glasgow (Scotland), has settled at Woodville, 100 miles S.W. of Napier.

DR. T. W. BELL, late of the Auckland Hospital, has settled at Helensville, 38 miles N.W. of Auckland.

DR. R. FAIRMAN has commenced practice at Opunake, 48 miles from New Plymouth.

QUEENSLAND.

DR. J. H. GRIFFIN, of Brisbane, has been elected Lecturer in Materia Medica and Pharmacy at the new College of Pharmacy.

DR. J. CHRISTIAN has removed from Allora to Port Douglas, on the shores of Trinity Bay, 1000 miles N.W. of Brisbane.

DR. C. C. CLAYWORTH, formerly of the Sydney Hospital, has been elected Surgeon of the Goondiwindi Hospital, in the place of Dr. Magill.

DR. S. M. OWENS, of Brisbane, has been re-elected Ophthalmic Surgeon of the Ipswich Hospital.

DR. E. ST. G. QUEELY has removed from Esk to Nanango, 130 miles N.W. from Brisbane.

SOUTH AUSTRALIA.

THE hospital at Burrundie, 200 miles from Port Darwin, has been closed by the Government, and the resident medical officer, Dr. Ternan, has been withdrawn.

MR. HORATIO ROSS BROWN, L. et L. Mid. R.C.P. et R.C.S. Edin. 1876, died suddenly at Snowtown, on January 9; the deceased gentleman arrived in the colony in 1877.

DRS. J. MICHIE and F. A. A. LYNCH have been appointed house surgeons, and Drs. F. Goldsmith and W. J. Gregerson house physicians in the Adelaide Hospital.

DR. T. A. HYNES, of the Adelaide Hospital, has been appointed a surgeon in the S. A. Military Forces.

VICTORIA.

TENDERS have been invited for the erection of the first of the country lunatic asylums which are to replace the huge asylum at Kew. The building is to be erected at Sunbury, between the Reformatory Schools and the railway station. It will be constructed strictly on the lines of the cottage system, and is intended to accommodate 750 patients. The cost will be about £120,000. There are at present 1,200 patients at Kew, including 200 imbeciles, and it is intended to provide for the balance of these by the erection of asylums on the cottage system at other places in the country districts.

A DIFFICULTY has arisen in connection with lady medical students at the Melbourne Hospital. Some of the surgeons are averse to performing operations with a half dozen lady students standing by deeply interested in the subject under dissection. Mr. Butters informed the committee, at a recent meeting, that the male students—who number nearly 150—are also deeply concerned in the matter of the mixing of sexes in the operating theatre, though whether their opinions on the point are attributable entirely to delicacy or in part to the fact that the six lady students always get the best places to watch surgical operations, and cannot be jostled out of them, was not made perfectly clear. Dr. Molloy informed the committee that some little difficulty was experienced in the same way at the Alfred Hospital. The objections in this case came also from the sterner sex. Some members of the committee were much surprised to learn that there were lady students in the Hospital, and the medical superintendent and the surgical staff were asked to send in reports concerning the difficulty arising from their presence at operations.

AT the last annual meeting of the Medical Society of Victoria, Dr. Jackson was unanimously elected President for the ensuing year. Professor Allen and Dr. Hinchcliff (Sandhurst), were elected Vice-Presidents.

THE Central Board of Health met for the last time under the old Act on January 23. The new Act came into operation on February 1.

THE number of deaths from typhoid in Melbourne and suburbs during the year 1889 was 558 as against 240 in 1888, and 338 in 1887. The number of deaths from diphtheria in 1889 was 329, as against 130 in 1888 and 64 in 1887.

FOR the fortnight ended 23rd January, 344 cases of typhoid, with 37 deaths, have been reported throughout the colony. There were also 64 cases of diphtheria, and 15 deaths.

THE number of cases of typhoid in the colony, reported to the Central Board of Health for the week ending February 1st, was 202, of which 23 were fatal. During the same period there were 53 cases of diphtheria, of which 17 were fatal.

A SERIOUS outbreak of diphtheria has occurred at Numurkah, 133 miles N. of Melbourne. Twenty-four cases occurred in January, of which six have proved fatal. Seven persons were attacked in one family, and three of them died.

AN outbreak of scarlet fever has taken place at Brighton, near Melbourne. Dr. Simons, the local Health Officer, has reported to the Central Board of Health that 18 cases were brought under his notice in one week. He attributes the spread of the disease to the milk supplied from a dairy at which a case occurred. The cases are of a mild character.

MR. WILLIAM SHAW, M.R.C.S. Eng. 1835, L.K.Q.C.P. Irel. 1850, an old colonist of 30 years' standing, died suddenly at Geelong on December 13; the deceased gentleman was Public Vaccinator and Health Officer for the district.

DR. WILLIAM EDWARD STOCK, M.D. Jena 1849, a colonist of 25 years' standing, died at his residence, Oakleigh, on January 23, at the age of 66.

THE Committee of the Alfred Hospital have granted a honorarium of £15 each to Dr. Schlesinger and Dr. B. Thomson for their services as lecturers to the nursing school of the hospital.

IN pursuance of the provisions of Section 17 of "The Lunacy Amendment Act 1888," the undermentioned medical practitioners have been appointed to examine patients on trial, and boarded out from lunatic asylums, viz.:—Drs. G. R. Eakins, Echuca; G. E. Garde, Maryborough; T. F. Jordan, Ballarat; E. H. C. Massey, Daylesford; H. M. Massey, Wycheproof; A. Mueller, Yackandandah; G. B. D. Macdonald, Newbridge; J. C. McKee, Eaglehawk; F. J. Newman, Geelong; R. G. Reid, Nagambie; S. Reynolds, Mansfield; S. Roberts, Romsey; M. J. Ryan, Kyneton; W. H. Semple, Kilmore; F. W. Towle, Drysdale.

DR. DAN ASTLEY GRESSWELL, the newly-appointed sanitary expert of the Victorian Central Board of Health, is expected to arrive in Melbourne about the middle of March.

DR. ANDREW HONMAN, of Williamstown, has been appointed to the position of Government Health Officer for the port of Williamstown, *vice* Dr. Figg resigned.

DR. J. W. MARTIN, late of the Creswick Hospital, has commenced practice at 215 Albert-road, South Melbourne.

THE Council of the Melbourne University have appointed Dr. Maudsley as *locum tenens* for Dr. Jamieson during his nine months' leave of absence.

DR. M. W. C. PERCEVAL, formerly of the Clunes Hospital, and late of Waratah (Tas.), has settled at Surrey Hills, near Melbourne.

DR. CHARLES WILLIAM ROHNER, M.D. Prague 1858, an old colonist of 25 years' standing, and well-known in the North-eastern district, mysteriously disappeared from his residence at San Remo on January 9.

At the February meeting of the Medical Board of Victoria, Miss E. Constance Stone, a native of St. Kilda (Melbourne), was duly registered as a medical practitioner, being the first lady doctor who has been granted registration in the Australasian Colonies.

We regret to have to announce the death of Dr. Henry Carter Wigg, M.B. 1866, M.D. 1869 Edin.; M. 1866, F. 1869, R. C. S. Eng.; M.D. (a.e.g.) Melb. 1886, who died suddenly at his residence, 220 Lygon-street, Carlton (Melbourne), on February 7, in the 46th year of his age. The deceased gentleman came to Australia as surgeon in charge of an immigrant vessel to Queensland in 1870; he then went to Melbourne and practised at Carlton ever since. At one time he held the appointment of pathologist to the Melbourne and Alfred Hospitals.

WEST AUSTRALIA.

DR. C. LOVEGROVE has settled at Fremantle, and Dr. D. Connor at Newcastle.

We see by the last *Lancet* received that Dr. J. H. Poland, in addition to the Public Health qualifications alluded to in our January issue, has also obtained the Diploma in Public Health of the Colleges of Physicians and Surgeons of England.

THE YEAR-BOOK OF TREATMENT FOR 1890 (5s.) will arrive here early in March. Orders are now being booked by L. Bruck, Medical Bookseller, Sydney.

BOWRAL.—Dr. Wilson has superior accommodation for medical boarders.

We have received from Messrs. Burroughs and Wellcome samples of Pinol-soap, Ichthyl-Lanoline soap, Lano-Creoline, Toilet Lanoline, Wyeth's Dialysed Iron, and their Thermo safeguard Feeding Bottle.

MEDICAL BOOKKEEPING.—The undersigned is prepared to keep the books and collect outstanding debts for medical practitioners. References on application. E. Ross, 530 Bourke-street, Surry Hills, Sydney.

"OAKLEIGH," WAKEFIELD-STREET EAST, ADELAIDE, SOUTH AUSTRALIA.—Comfortable accommodation for ladies during accouchement. Ladies or gentlemen requiring medical or surgical treatment will find careful nursing and every attention. Convalescent patients (or other visitors) accommodated provided they are not suffering from any infectious disease. NO SUCH CASE WILL BE RECEIVED ON ANY ACCOUNT. References to leading medical men. Telephone communication with the doctors. Terms, &c., on application to Mrs. Taylor, "Oakleigh," Wakefield-street East, Adelaide, South Australia.

BARGAIN.—CABINET FOR OFFICE BATTERY of 30 Leclanche cells, with dial-collector, commutator, interrupter, &c., &c., and room for Milliampere meter and Faradic coil,—*"Electrician," A. M. Gazette Office,*

PROCEEDINGS OF COLONIAL MEDICAL BOARDS.

The following gentlemen, having presented their diplomas, have been duly registered as legally qualified Medical Practitioners by the respective Boards:—

NEW SOUTH WALES.

Thompson, Robert, M.B. 1888; B.S. 1888 Univ. Durham; M.R.C.S. Eng. 1888; L.R.C.P. Lond. 1888.
Souter, John Francis, M.B. & Ch.M. Univ. Aberd. 1888.
Kelly, William Augustine, L.K.Q.C.P. Irel. 1886; L.R.C.S. Irel. 1886.
Vereker-Bindon, William John, M.B. 1875; M.D. 1878 Univ. Edin.; L.R.C.P. Edin. 1874; D. Sc. (Public Health) Edin. 1877; L. 1874; F. 1876, R.C.S. Edin.; M.S. Univ. Edin. 1875.
Rygate, Charles Daniel Hartley, M.R.C.S. Eng. 1889; L.R.O.P. Lond. 1889.

NEW ZEALAND.

Myles, John, M.B., Ch.B., F.R.C.S.I.
Christie, William Walls, M.D. & Ch.M. Glas. 1885.
Hunter, James, M.D. & Ch.M. Roy. Univ. Irel. 1888; L. Mid. K.Q.C.P.
Somerville, John, M.B. & Ch.M.
Stevens, William Edward, M.R.C.S. Eng.; L.R.C.P. Lond. 1888.

VICTORIA.

Quilter, John, M.B. Melb. 1889.
Wheeler, Abraham, M.B. & Ch.M. Edin. 1889.
Taylor, William Marshall, M.R.C.S. Eng. 1879.
Mallet, Charles, L. & L. Mid. R.C.P. & R.C.S. Edin. 1888; L.F.P.S. Glas. 1888.
Doyle, Henry Martin, M.R.C.S. Eng. 1886; L.R.C.P. Lond. 1889; L.S.A. Lond. 1886.
Müller, Charles Albert, M.B. Melb. 1889.
Gleeson, Patrick Francis, M.B. Melb. 1889.
Barrett, John Edward, M.B. Melb. 1889.
Vickery, Robert Glen, M.B. Melb. 1889.
Barker, John, M.B. 1885, M.D. 1887, Durham; M.R.C.S. Eng. 1886; L.S.A. Lond. 1885.
Smith, Robert, L. & L. Mid. R.C.S. Irel. 1889; L.A.H. Dubl. 1889.
Cowen, Baruch Stewart, M.B. & Ch.M. Glas. 1885.
Jermyn, Walter Herbert, M.B. Melb. 1889.
Gleeson, Edmund Joseph, M.B. Melb. 1889.
Scott, John Melby, M.B. Melb. 1889.
Bennie, Alexander Bruce, M.B. Melb. 1889.
Morrison, Reginald Herbert, M.B. & Ch.M. Edin. 1888.

Additional qualifications registered:—

Drake, Francis J., Ch.B. Melb. 1888.
Bobardt, Albert O., Ch.B. Melb. 1889.
Jermyn, Frederick D., Ch.B. Melb. 1888.
Martin, John W., M.B. & Ch.M. Edin. 1888.

WESTERN AUSTRALIA.

Connor, Daniel, L. & L. Mid. R.C.S.I. 1889; L.A.H. Dub. 1889.
Lovegrove, Charles, M.D. & Ch.M. Toronto 1888; L. & L. Mid. R.C.P. Ed. 1881; L.F.P.S. Glas. 1881.

BIRTHS AND MARRIAGE.

. The charge for inserting announcements of Births, Marriages, and Deaths is 2s. 6d., which should be forwarded in stamps with the announcement.

BIRTHS.

CUPPAIDGE.—On the 19th January, at One-mile, Gympie, (Qu.), the wife of J. Loftus Cuppaidge, M.D., of a daughter.
KNAGGS.—January 13th, at College Street, Sydney, the wife of Samuel T. Knaggs, M.D., of a daughter.
MONTGOMERY.—On the 13th January, the wife of Dr. J. P. Montgomery, Traralgon (Vic.), of a son.
O'NEILL.—On the 20th January, the wife of John O'Neill, M.D., Maldon (Vic.), of a son.
WATKINS.—January 23rd, at Manly, (Sydney), the wife of Dr. Sydney C. Watkins of a daughter.

MARRIAGE.

GRAHAM—MILLARD.—January 7th, at the pro-Cathedral, Newcastle, N.S.W., James Graham, M.A., M.D., to Fanny, second daughter of the Rev. H. S. Millard, M.A., Newcastle Grammar School.

REPORTED MORTALITY FOR THE MONTH OF DECEMBER, 1889.

Cities and Districts.	Population.	Births Registered.	Deaths Registered.	Deaths under Five Years.	Number of Deaths from									
					Measles.	Scarlet Fever.	Croup and Diphtheria.	Whooping Cough.	Typhoid Fever.	Dysentery and Diarrhoea.	Phthisis.	Heart Disease.	Cancer.	Child-bearing.
N. S. WALES.														
Sydney	132,846	289	217	123	...	...	4	15	10	25	15	8	6	1
Suburbs	216,849	735	468	294	...	...	17	46	11	48	27	19	12	3
NEW ZEALAND.														
Auckland	35,858	72	23	9	...	...	...	...	...	3	3	...	3	...
Christchurch	16,455	39	11	3	...	...	...	...	...	...	...	...	...	...
Dunedin	23,546	49	20	4	...	...	...	...	...	...	...	1	1	...
Wellington	29,075	64	30	14	...	4	1	...	1	2	2	2	1	...
QUEENSLAND.														
Brisbane	51,689	186	84	46	}	...	4	3	4	16	4	1	4	...
Suburbs	21,960	140	44	34		...	...	...	...	...	...	...	...	...
SOUTH AUSTRALIA.														
Adelaide	317,909	746	319	147	...	...	11	1	3	58	20	13	14	3
Adelaide	43,750	65	85	24	...	...	3	...	1	9	11	3	6	...
TASMANIA.														
Hobart	34,906	64	69	31	...	...	2	4	...	4	1	8	4	1
Launceston	21,497	54	30	13	...	...	1	...	1	3	2	3	...	...
Country Districts	92,353	257	76	...	...	...	3	...	1	6	...	...	...	...
VICTORIA.														
Melbourne	75,400	139	121	} 553	...	3	30	21	31	102	80	45	35	13
Suburbs	362,385	1,231	895		...	...	...	...	...	...	...	...	...	...

METEOROLOGICAL OBSERVATIONS FOR DECEMBER, 1889.

STATIONS.	THERMOMETER.				Mean Height of Barometer.	RAIN.		Mean Humidity.	Prevailing Wind.
	Maximum Sun.	Maximum Shade.	Mean Shade.	Minimum Shade.		Depth.	Days.		
						Inches.			
Adelaide—Lat. 34° 55' 33" S. ; Long. 138° 36' E. ....	...	98.9	69.9	50.3	29.771	...	...	...	...
Auckland—Lat. 36° 50' 1" S. ; Long. 174° 49' 2" E.	143.76	76	64.8	53.5	...	2.630	9	70	...
Brisbane—Lat. 27° 28' 3" S. ; Long. 153° 16' 15" E.	139.5	94.0	76.6	64.1	29.861	3.493	18	73	S.E.
Christchurch—Lat. 43° 32' 16" S. ; Long. 172° 38' 59" E.	150.8	88	61.8	36	...	1.427	11	58	...
Dunedin—Lat. 45° 52' 11" S. ; Long. 170° 31' 11" E.	140	77	59.7	44	...	4.070	12	82	...
Hobart—Lat. 42° 53' 32" S. ; Long. 147° 22' 20" E. ....	...	86.8	60.1	35.8	29.683	3.49	20	70	...
Launceston—Lat. 41° 30' S. ; Long. 147° 14' E. ....	...	81.6	62	40	29.755	1.71	11	85	...
Melbourne—Lat. 37° 49' 54" S. ; Long. 144° 58' 42" E. ....	...	99.8	64	47	29.777	1.62	7	...	...
Sydney—Lat. 33° 51' 41" S. ; Long. 151° 11' 49" E. ....	...	99.5	72.2	61.3	29.867	2.19	17	65	N.E.
Wellington—Lat. 41° 16' 25" S. ; Long. 174° 47' 25" E.	13.9	75.5	61.3	45.2	...	2.730	13	72	...

AUSTRALASIAN MEDICAL GAZETTE.

ORIGINAL ARTICLES.

LEPROSY : IN ITS RELATION TO THE EUROPEAN POPULATION OF AUSTRALIA.

By JOHN M. CREED, L.R.C.P., M.R.C.S.,
MEMBER OF THE LEGISLATIVE COUNCIL OF NEW
SOUTH WALES.

It is not my intention, nor do I think it will be the desire of the members of the Congress, that I should enter very deeply in this paper into the pathology and symptoms of leprosy, my object being to point out in a concise manner the amount of danger to which a community such as that of these colonies is exposed by the presence in it of the few lepers who are now here. I think that only good can follow an attempt to point out how comparatively ungrounded is the unreasoning terror in which this disease is held by most non-professional persons, and to show that the danger of infection is comparatively trifling.

I do not, however, for a moment wish it to be understood that I do not think the disease a terrible one for its unhappy victims when once infected. Leprosy may affect any portion of the body. It is essentially a constitutional disorder, indicative of a cachexia, or depressed condition of the general system. Its outward manifestation occurs in three forms—the tuberculated, the maculated, and the anæsthetic. One or all may be present in the same subject at the same time. In *lepra maculosa* the first symptoms are the appearance on the skin of spots varying in size, having an area of from half a square inch to five square inches or more. At first the colour is light red, disappearing on pressure. This by degrees gets darker, gradually increasing in intensity until it becomes a dark brown. The surface of the spot is shining and smooth and the skin feels like fine velvet. The latter characteristic *Hebra* considered absolutely diagnostic. The affected part is not much elevated, but between the fingers the skin feels hardened and thickened, and is sometimes very sensitive. The spots are generally situated on the trunk and limbs. They grow peripherally, the centre turning into yellow brown, while the fresh outer portion is red and slightly swollen. They never perspire. The whole spot may disappear.

In *lepra tuberculosa* the nodules may grow out of the spots of the last form, or they may appear

independently, they may vary in size from a shot to a walnut, they generally first appear on the face, and are almost always in the greatest proportion on this part. The face is broadened, puffed, and brown or red in colour. On the tubercles the hair is thin or completely lost. The nose is generally thickened and, as well as the lips, covered with knots. The lobes of the ears are converted into thick, rugged masses. The tubercles may appear on all parts of the body and limbs. Next to the face, however, the hands and feet show the most striking appearance; they become deformed; the digits are enlarged, especially at the tips, and are frequently kept apart by their thickened extremities; the joints become stiff and often immovable. The knots may atrophy, be re-absorbed, or turn into abscesses and ulcerations. Destruction of the tissues sets in and portions of the hands or feet may be spontaneously amputated and death ensue after some years, according to Drs. Danielssen and Boeck, on an average in about nine or ten, though many patients live for many years, and occasionally life is prolonged to old age. Lepers, however, do not usually die directly of leprosy, but of diarrhoea or dysentery, of inflammation of the lungs or air passages, or of disease of the kidneys. In these varieties of leprosy neuralgia is said to be a special symptom; but leprosy neuralgia seems to be limited to the ulnar nerve, a little above the inner condyle of the humerus; to the auricularis magnus nerve on the sterno-mastoid muscle and to the posterior tibial nerve along its course; but the ulnar nerve is attacked by this neuralgia most frequently and most severely. These nerves may be felt even in the early stages of the disease, when there is no neuralgia, to have assumed a tense cord-like character. Marked changes have been noted on post-mortem examination in the nerves of lepers, by Drs. Danielssen and Boeck of Norway and Dr. Carter of Bombay, the latter's more exact observations confirming those of the former.

The third form—*lepra anæsthetica*—is, as a rule, associated with one or both of the others, but it may occur alone. When it is the original form large vesicles first appear on the skin, which will, probably, be mistaken for pemphigus, and for a time the sensibility of the skin remains normal, but subsequently the seats of the vesicles lose all feeling. The anæsthetic spots may appear on an otherwise apparently healthy skin, so that patients first gain a knowledge of it by medical examination or by the painless result of some accident, for they may burn, scald, or cut themselves without being conscious of it, except from

seeing the thing happen. This insensibility is not confined to the skin, but extends to the deeper tissues beneath the anæsthetic spots.

The disease may make its appearance at any period of life, even in early childhood, but from the age of puberty to that of maturity is the more general time of its incidence. Until the discovery of the bacillus of leprosy those observers who had the best means of judging, with few exceptions, were of opinion that the disease was non-contagious; and the numerous examples given, of continued intimate association for years, even as husband and wife, by healthy persons with lepers, without the transmission of the disease, gave such support to this view that it was practically incontestable. The presence of this specific germ, however, gives such support to the opinions of those who believe that it is contagious that I think probability is in accordance with this view. At the same time the difficulty of transmission is so great, excepting under circumstances extremely favourable to the development of the disease, that there is but little danger of infection to the white population of these colonies. The long period of incubation, often many years, renders it the more difficult to decide this question positively. A case is quoted from Torneo, in which a boy, having thrust a knife into an anæsthetic spot of a leprosy child, afterwards incised with it his own thigh. He had no further dealings with lepers, but nineteen years afterwards developed the disease. Dr. Massanao Goto, a Japanese physician, educated in European medicine, stated in his graduation thesis at the Cooper Medical College in San Francisco, that, by the permission of the Hawaiian Government, an attempt was made to reproduce leprosy in a convict* by inoculation with leprosy matter, but that two years afterwards he had developed no signs of the disease. According to the same gentleman, who was practising in the Sandwich Islands, and paid great attention to leprosy, the disease was unknown there until 1859, when it first occurred in the persons of two Chinese coolies; but in 1884 there were upwards of 1,200 lepers, about 1.5 per cent. of the population in this group of islands, 721 of whom were, in that year, confined in the leper settlement of Molokai and 186 in a branch hospital in the suburbs of Honolulu. About 300 more were met with by him in his private practice who were not under Government supervision.

In view of the fact that in twenty-five years the disease manifested itself in 1.5 per cent. of the population, it is impossible to deny that it must be communicable by contagion or infection; but

* At a later date this man, however, developed leprosy and was sent to the leper settlement, where he now is.

when this is considered it must be borne in mind how extremely favourable to the development of the disease are the conditions of life of these people. In the report of the Committee on Leprosy of the Royal College of Physicians are given a number of instances, by various observers in all parts of the world, of the most intimate relations having existed for years between healthy persons and others suffering from the disease without its being communicated. Dr. Goto made careful inquiry as to hereditary transmission in leprosy, and succeeded in collecting sufficient data in Japan to show that the disease occurs from hereditary transmission in about fifty per cent. of cases. Leprosy, when inherited from the mother, is more severe than when inherited from the father, and is more severe when inherited from both parents than from one alone. The disease may skip a generation or more to re-appear in later descendants, who have it in a milder form. This physician, as well as other observers, are of opinion that the presence of constitutional syphilis increases the susceptibility to leprosy, and that in those cases in which hereditary leprosy is latent in an individual the infection of syphilis will bring it into activity. He claims considerable success in the treatment of the disease, and is said to have cured several cases. The *Japanese Mail* says: "Dr. Arai Saku, a Japanese practitioner, who has charge of the Shusai Hospital, has been most successful in treating cases of leprosy amongst his countrymen. It is said that this was made known to the Indian Government, and resulted in their writing to Dr. Arai Saku to invite him to go over to India and there try his hand on confirmed cases." It must not be forgotten that the practice of medicine in Japan is of the most advanced European type, and that its conduct is regulated by Imperial decree as to study and qualification for practice, far in advance of the regulations in these colonies.

The disease is found in all parts of the world, and under the most diverse circumstances of climate, latitude and mode of life, but in every place where it is present the conditions of life of the people are such as to lower vitality. It is found so far from the equator as 70° north, and in such cold countries as Iceland, Norway, the Baltic provinces of Russia, and New Brunswick, but it is, perhaps, more prevalent in the warmer climates and in damp, low-lying situations. In the middle ages it was common in all the countries of Europe, including Great Britain and Ireland, in which latter country it was prevalent until the close of the seventeenth century. The disappearance of the disease in the countries of a higher civilization is accounted for by the vast improvement which has taken place in the food and

dwelling of the people during the last two or three centuries. Prior to this, for at least six months of the year, the entire animal food of the population consisted of salt meat or fish, often in a semi-putrid state, whilst wheaten bread was an unknown luxury to the majority and fresh vegetables were unprocureable, except in the summer months. The dwellings were unventilated and often filthy in the extreme, the rushes or straw with which the floors were strewn being frequently left until they were rotten before removal, this insanitary condition being added to by the débris of food dropped or thrown down by persons eating. Personal cleanliness was almost an unknown thing in those days, no greater proof of which can be advanced than the curious fact brought into prominence by "Saint Beuve" in a review of the diaries of the physicians of Louis XIV. of France. Of this monarch it is recorded that after childhood he took but one bath, which he found so distasteful that he vowed he would never take another, and it is believed he kept his word. When such a thing is recorded of so great a personage—the head of the most refined court of Europe at a comparatively late period—what must have been the condition of the lower classes during the time in which leprosy was prevalent in that continent. Even in the great houses men slept on straw in the large hall, often with a common covering; whilst clothes were made of such lasting material, and were so passed from one to another, as must have greatly aided the transmission of disease of all kinds. These clothes, it must be remembered, were worn by, at all events, the lower classes without body-linen.

As to the conditions under which leprosy exists in these times, we have the fullest information in the answers to the interrogatories put by the Committee of the College of Physicians of London, who made inquiry some twenty-five years since. Almost without exception the answers show that the disease rarely attacked any but persons living under conditions of the most insanitary kind, and that in the majority of instances it showed the greatest activity where the diet consisted principally of salt fish, often semi-putrescent, with dry vegetable food, mainly consisting of inferior and damaged grain, and that in those places where the patients had had a fair supply of fresh meat there had been a complete absence of fresh vegetables.

In Hawaia, where the spread of the disease has been more rapid than anywhere else, the staple diet is chiefly vegetable, with fish; the former is generally prepared so as to be in a fermented or even partially putrid state before being eaten. Dr. Thomson, surgeon to the 58th Regiment in 1853, accounted for the presence of leprosy

amongst the Maories by their neglect of personal cleanliness, and their fondness for putrid vegetable food. He says that the disease was more common just in proportion to the fondness of the people for this kind of diet. He remarks that "since the improvement in the condition of the New Zealanders by intercourse with Europeans, the disease is becoming rare."

In Australia, in 1865, there were no known lepers except in Victoria, which at that time had thirteen. To the present time there have been none known in South Australia or Tasmania, and the number has decreased in Victoria to five, but there are now ten* in New South Wales and several in Queensland—the exact number I have been unable to ascertain from the health authorities of that colony. The lepers in the older colonies are all Chinese immigrants, with two exceptions*—one of whom is a Malay, a native of Java; the other a young European, aged twenty-seven, born in Sydney. The latter is, as far as I can ascertain, the only instance of a white leper known in Australasia, except the young daughter of a British official in a South Sea island. His is a well-marked case of the tuberculated variety, but little information can be obtained from him as to the probable source of his disease. He, however, denies all intimate association with the Chinese.

To summarize, I submit we may fairly assume:—

(1) That the disease is contagious, but only under circumstances (extremely favourable to its propagation) which lower the vital powers of the persons exposed to it; and that there is no real danger to people who live with good sanitary surroundings, have a fitting, wholesome diet, and are personally cleanly, however intimate their association with the leper is.

(2) That the disease may be hereditary, but frequently skips generations, and becomes less severe as the descent becomes remote.

(3) That the presence of constitutional syphilis increases the liability to the disease.

(4) That though very intractable, it is not incurable, and that cases improve under treatment; and there are occasionally instances of spontaneous cure.

(5) That there are other diseases much more dangerous to life and health rife in these colonies, and that there is no just reason for the unreasoning dread and horror in which leprosy is held by the majority of the people.

* The lepers in New South Wales have since increased to thirteen, one of the three recently discovered being a native youth of British descent, who had had very intimate association with the Chinese living near his father's residence.

CLINICAL RECORDS OF CASES IN PRINCE ALFRED HOSPITAL, SYDNEY.

UNDER THE CARE OF DR. A. SHEWEN, HON.
PHYSICIAN.

HYDATIDS IN PELVIS.

M. M., a girl of about 20, attended at the out-patient department on account of fits. When examined she was found to be also suffering from a large tumour in the pelvis, enlargement of the liver, and a small tumour beneath the navel. She gave rather a curious history of herself. About six years ago she got enormously ascitic, with distended superficial veins, and was subsequently tapped. After the tapping she got quite well and has never been troubled with ascites since. She was unaware that there was any tumour in the pelvis, but has been unable to hold her urine lately.

When admitted to the ward the liver was felt below the ribs for nearly a hand's-breadth, the edge was hard and well defined, and there was but little increase of dullness upwards or bulging of the costal cartilages. Attached to its lumbar margin was a firm irregular mass about the size of a small orange. The tumour beneath the navel was attached to the abdominal wall and was hard and irregular to the touch. When examined P. V., the vagina was found jammed against the pubes by a mass behind, so much so that the finger on entering passed directly upwards behind the pubes, and could be easily felt through the abdominal walls anteriorly.

The exploratory syringe inserted into the liver gave us no fluid, on the contrary, the substance felt unusually hard and resistant. But the pelvic mass gave us undoubted hydatid fluid with pus, though it was evident that it was packed with cysts. Mr. Hankins was kind enough to make a free incision into the mass per vaginam, and about three pints of the most horribly stinking fluid, consisting of hundreds of small cysts, old cyst walls and pus was evacuated, and an india rubber flange tube about three quarters of an inch in diameter was inserted. So far the patient has made an uninterrupted recovery, and has never had an epileptic attack since the operation.

Remarks.—The interest attached to this case lies in the question as to whether the other tumours are of hydatid origin. No doubt hydatid tumours do undergo spontaneous cure and eventually dry up, but that three independent ones should do so simultaneously is very curious. This is the fourth case I have had under my care in which the patient has applied for the relief of some intercurrent trouble and was found to be suffering from suppurating hydatids. It is im-

possible to emphasize too strongly the necessity of a large drainage tube in these cases of multiple cysts, it simplifies matters immensely if an opening be made large enough to admit the forefinger. Some cysts or the mother wall are almost certain to be left behind, and with an opening only the size of a quill it is very difficult to get them away. I like a tube with a lumen of at least half an inch. Another point worth noting is the great advantage of turning out all the daughter-cysts and pieces of loose membrane when the tumour is opened; this can usually be thoroughly done by passing the vaginal portion of a Higginson's springe down to the bottom of the cavity and running in a sharp current of water. The quickness with which hydatid tumours contract after emptying is astonishing.

HYDATID OF THE KIDNEY.

A. B., a girl of about 20, was sent into the hospital from the northern districts. It appeared that she had been suffering from a tumour on the left side of the abdomen for some time, but within the last two or three months it had caused her very considerable pain.

On admission we found a large ill-defined mass in her abdomen which could be grasped and moved between the two hands, and which reached from two inches to the right of the navel round to the left lumbar region, exactly in position of the left kidney; upwards the mass was limited by the left costal cartilages, but below it extended nearly to the brim of the pelvis. Manipulation caused considerable pain. There was no absolute dullness anywhere over the tumour, nor did it, judged by the touch, seem to be anywhere in direct contact with the abdominal parietes. Diagnosis—renal tumour possibly hydatid.

After thoroughly emptying the intestines an endeavour was made to ascertain the nature of the mass by means of the exploratory syringe. After several unsuccessful attempts we got a clear fluid containing beautiful scolices at the extreme border to the right of the navel. It was now quite clear that the mass consisted of *packed* hydatids.

A few days afterwards Mr. Hankins operated by an incision in the loins, and evacuated about a pint of small cysts and broken down membrane, and laid open a secondary cyst lying very deep and containing a clear fluid which we had no doubt tapped with the exploratory syringe. As far as could be ascertained the mass appeared to be the kidney itself.

Remarks.—This case is a very good example of the difficulty there is sometimes in getting sufficient fluid for microscopical examination from hydatid tumours which are packed with small cysts and hydatid debris.

ON HOMŒOPATHY.

BY THOS. L. BANCROFT, M.B., BRISBANE.

HOMŒOPATHY, strictly defined, is the art of treating diseases by drugs, which in poisonous doses produce symptoms resembling the diseases for which they are thought to be beneficial. Some medicines, such as henbane, have opposite actions when administered in small or in large dose. In moderate or medicinal doses henbane produces sleep, but in poisonous doses it causes delirium. For ages past it has been used as a remedy in the delirium of mania.

Hahnemann, who enunciated the doctrine of homœopathy, founded it upon the assumption that like henbane all drugs had contradictory or opposite actions, but experience has shown that there are but a few drugs which have such an action. His doctrine, therefore, was based upon an untruth.

Alcohol in excess causes delirium, but in small doses it causes sleep, and may be a useful remedy in some diseases where delirium is a symptom—certainly not in alcoholic delirium.

Opium on the other hand causes sleep whether in small or excessive doses; the homœopathist should give opium in coma and other states of unconsciousness; he should, too, administer strychnine in tetanus, because strychnine in excessive dose causes tetanic symptoms.

He knows, however, that such treatment would hasten a fatal termination.

Why is it if "*homœopathy*," or "*like cures like*," is not a fallacy, that a small dose of strychnine will not cure a man poisoned with the same substance?

The following definition of homœopathy is given by Lauder Brunton:

"The opposite action of large and small doses seems to be the basis of truth on which the doctrine of homœopathy has been founded. The irrational practice of giving infinitesimal doses has of course nothing to do with the principle of homœopathy.

The only requisite is that the dose be smaller than would be sufficient to produce in a healthy man symptoms similar to those of the disease. Now in the case of some drugs this may be exactly equivalent to giving a drug which produces symptoms opposite to those of the disease, and then we can readily see the possibility of the morbid changes being counteracted by the action of the drug and benefit resulting from the treatment. For example, large doses of digitalis render the pulse extremely rapid, but moderate ones slow it. The moderate administration, when there is a rapid pulse, is sometimes beneficial; this

might be called homœopathic treatment, inasmuch as the dose administered is smaller than that which would make the pulse rapid in a healthy man, but it might also be called antipathic, inasmuch as the same dose administered to a healthy person would also slow the pulse. Homœopathy can therefore not be looked upon as a universal rule of practice, and the adoption of any such empirical rule must certainly do harm by leading those who believe in it to rest content in ignorance instead of seeking after a system of rational therapeutics."

Oliver Wendell Holmes says of his lecture, entitled "*Homœopathy and its Kindred Delusions*:"—"I wish to state, for the sake of any who may be interested in this subject, that I shall treat it, not by ridicule, but by argument, perhaps with great freedom, but with good temper and in peaceable language, with very little hope of reclaiming converts, with no desire of making enemies, but with a firm belief that its pretensions and assertions cannot stand before a single hour of calm investigation."

Nowadays, however, few practise homœopathy, but many calling themselves homœopathists carry on a practice of imposition; I refer to the principle of treatment with infinitesimal doses or pilules.

This simply amounts to treating disease without medicine, and, indeed, in some few cases medicines can be dispensed with. It is in these cases that the so-called homœopathist succeeds, but he ignominiously fails when he adopts the same course with diseases, some of which are easily and readily curable by drugs.

What possible good can such a homœopath do to a man suffering from rheumatic fever, from ague, from gout, from itch, from syphilis, from heart disease? It is merely in a few diseases where drugs hitherto used have failed to effect a cure that his results are at all comparable with those of a physician. I refer to cases like typhoid fever, pneumonia, consumption, leprosy, tetanus; but even in these diseases physicians can give relief by treating symptoms.

I know a pharmacist who has several testimonials from homœopaths extolling the excellency of the homœopathic medicines he sold; he merely sold them water. This has been his practice for twenty years, and his trade to-day is as large as ever. Others use water or spirit of wine, one I know uses absolute alcohol for the reason that it quickly evaporates, and upon that account he makes the more sales. The pilules are made of sugar and are bought in quantity in London, the chemist merely fills little bottles with them and attaches labels with the various names; the only difference between one bottle of pilules and another is the different label.

In the United States homœopaths say it is unsafe to use a stronger solution than the ten millionth dilution.

The ten millionth dilution ought to be made in the following way :

One drop of tincture is mixed with one hundred drops of water or spirit of wine to make the first dilution ; one drop of the first dilution is placed in one hundred drops of water to constitute the second, one drop of which is mixed with one hundred drops of water, the result being the third dilution and so on up to the ten millionth.

One drop of mother tincture thus utilized would make more fluid—when of the strength required by the American homœopaths—than there is water in the Pacific Ocean.

To save trouble, however, unmanipulated water or spirit is generally sold instead, and is for all good purposes equally efficacious. Some pharmacists may, indeed, conscientiously put the drop of mother tincture in the first dilution, and, I believe, a good many homœopaths use a solution of the third dilution and not find it too strong!

Let us see how much tincture there would be in one drop of the third dilution.

One drop of tincture in one hundred drops of water constitutes the first dilution. One drop of this, containing the one hundredth part of a drop of the tincture, is put into a hundred drops of water to form the second dilution. One drop of the second dilution therefore contains the one ten thousandth of a drop of tincture ; this amount is put into one hundred drops of water, the result is the third dilution, and one drop of it would contain the one millionth part of a drop of the tincture.

Now I would like to know what possible effect one millionth of a drop of tincture of *nux vomica* or any other drug, or even a million times this amount would bring about. Physicians use tincture of *nux vomica* in twenty drop doses, and frequently have to give larger doses before they can produce any action whatever. They start, therefore, with a dose of *nux vomica* twenty million times larger than the homœopaths. If they could possibly get the required benefit from a smaller dose of *nux vomica*, what possible object could there be in giving more than what was sufficient? The rule in medical practice has been, and always must be, to use the smallest possible dose to effect a cure.

It is shameful that unprincipled practitioners are allowed, with perfect impunity, to fleece and gull into belief of improvement unsuspecting persons whose diseases in the mean time are, as a consequence, allowed to obtain permanent hold, and sometime to become incurable even by the

treatment, which, had it been adopted earlier, might have restored them to health.

A few people, apparently sincere, say they believe in this treatment, they have seen cases get well under it, which satisfies them.

They accept as a truth the fallacy of "*post hoc propter hoc*."

These are the people, who are ever a hindrance to progress, but for them quackery in all its manifold shapes would never have had an existence.

It is from the credulous and the ignorant that the herbalist, the galvanist, the hydropathist, the homœopathist, *et hoc genus omne*, get their gain. These practitioners, whether possessing diplomas or not, can only be viewed by anyone with average common sense as impostors and charlatans.

THE MECHANICAL TREATMENT OF DISPLACEMENTS OF THE UTERUS.*

By W. V. JAKINS, L.R.C.P., L.M., &C., FELL.
OBST. SOC. LOND.

My desire for the next few minutes will be to compress into as short time as possible my experience of the past 20 years in the mechanical treatment of displacements of the uterus. I shall therefore trouble you neither with questions from authorities nor with cases in support of my statements, preferring rather to rely upon your own everyday experience, which I think will be in accord more or less with what I have to say.

For convenience then let us consider the uterus as placed in the middle line of the pelvis between the bladder and the rectum, as fixed anteriorly by ligaments to which the bladder is attached, posteriorly by ligaments on the left side of which is attached the rectum, and laterally by ligaments in which are contained the round ligaments, the fallopian tubes and the ovaries. These uterine ligaments are composed of peritoneum, containing involuntary muscular fibres, elastic and fibrous tissue. The round ligaments are supposed to end at the crest of the pubis and in the fascia adjoining. All these ligaments are well supplied with lymphatics, nerves and blood-vessels, which are continuous more or less with those of the uterus. In the dead body these ligaments are slack and the uterus drops. In life and health my experience is that these ligaments are always more or less tense, in fact that they act as *suspensory ligaments to the uterus*, yet yielding with every movement of the body ; therefore, as one might expect, when a healthy woman stands erect there is no downward pressure whatever on the tissues in the floor of the pelvis. Thus even

* This paper was appointed to be read at the late Intercolonial Medical Congress, but like others it was omitted for want of time.

in severely-torn perineums there is no uterine displacement. In making this statement I am aware of the importance placed by many upon the so-called *perineal body*—that wedge of fibrous muscular and areolar tissue which stretches from the orifice of the vagina to the anus. In years gone by I have wondered at the lack of displacement and even of discomfort in mothers of large families with perineums torn right along almost to the verge of the anus, till by degrees I have come to the conclusion that it has no part in supporting the uterus.

Look at this matter in another way. Let the suspensory ligaments of the uterus lose their tone when the perineum is torn, out comes the uterus; stitch up the perineum even to almost occlude the orifice of the vagina, and still the uterus will gradually and with certainty protrude. No perineal body, much less any surgically-made human septum, can withstand the inspiratory effort of respiration which is always towards the pelvic outlet. Mr. Hutchinson gives the force of an ordinary inspiration as equal to a force of 200 lb. pressure, of a forced inspiration about $\frac{1}{3}$ more. The diaphragm—a voluntary muscle—would not lessen this, although the stomach and intestines might, yet taking it at a low estimate, say a force equivalent to 100 lb. 16 times a minute for life, and then we can form some idea of the tendency of the uterus to become displaced. But let us support the uterus from the vagina with a pessary resting on the *sacro sciatic* ligaments, and we shall find as a rule these ligaments strong enough to resist the inspiratory downward pressure; thus we gain time in which to restore the tone of the uterine ligaments, and so do away with any further use of the pessary. Even if the *sacro sciatic* ligaments themselves are relaxed support can always be obtained from parts adjoining, although two pessaries will sometimes be needed instead of one.

To restore the tone of the uterine ligaments requires usually about six months, sometimes a few weeks only; occasionally a pessary must be worn for years.

If what I have advanced be correct we can account for the failure of vaginal plastic operations for displacements of the uterus. In *Alexander's operation* for shortening the round ligaments and thus relieving uterine displacement, some idea seems to have been entertained of the suspensory character of this ligament, but what an overlooking of its structure to imagine that an elastic, contractile and erectile tissue can be treated as a hempen cord, to be tied and shortened at will. Well may the operation not stand the test of time, for the more you stretch living muscular and elastic tissue the weaker it gets.

These remarks will have prepared you for the aetiology of uterine displacements. As a rule I find them caused by an exaggerated inspiratory movement by lifting a weight, by making a false step, or a sudden fall—or as I have said elsewhere, what causes hernia in a man generally causes uterine displacement in a woman; localized inflammations and hæmorrhages I have found but seldom as predisposing causes. There is usually weakness of one or more uterine ligaments, costiveness predisposing to anterior displacements; retention of urine to posterior displacements; frequent parturition and especially miscarriages predisposing to displacements generally.

Of the *nature of the mechanical treatment* I have but little to say, save that I have long ago given up all external supports, that my usual instrument is a vaginal ring pessary or an intra-uterine stem. Moreover, all my vaginal pessaries can be removed by the patient herself, and neither the vaginal nor the intra-uterine interfere with sexual intercourse. In fact, so little inconvenience do they occasion that their existence is often forgotten; one aged woman wore a ring pessary for nine years, the middle-aged mother of a large family wore an intra-uterine stem for ten years, and probably still for the last three years continues to wear it. As a rule instruments never require removal for cleansing. In most cases special attention to the general health is advisable before beginning this treatment. To sum up, whichever ligament has given way take off the tension from it by supporting the uterus mechanically with a vaginal pessary or an intra-uterine stem till the tone of the ligament is restored, and then you can remove your support; even strong adhesions will gradually give way before treatment applied on these principles.

Let us turn to another matter. One is sometimes asked, how is it that a woman may have severe uterine displacement and yet suffer no inconvenience, being in utter ignorance of her condition, in other words, *what makes a displacement pathological*? In some cases without doubt, pressure of the displacement on other parts, interference in blood supply and circulation, pressure on certain nerves, will account for the suffering caused by the displacement; but how account for the want of suffering, often in severe displacements, even with strong adhesions; is the collateral circulation sufficient to obviate the interference with the blood or nerve supply? Here, I feel, we have much to learn.

Take another matter. Some of you may say, how is it that the differences of opinion in all lands are so great as to the value of mechanical treatment?

I must still repeat what I have been saying for

years : some men have not the requisite sense of touch accurately to apply a pessary, others have not the patience nor the mechanical ability, nor the infinitude of resource necessary. One of the best men in London for years boasted that he had never introduced a pessary ; one of the best men in these lands was treating a patient unsuccessfully because the instrument was upside down.

In conclusion I may say that I have practised this mechanical treatment to the absolute exclusion of all operations for twenty years ; I am able to say there is no case in which it cannot be successfully used whatever the complication or however grave the condition ; tumours, abscesses, pregnancy, are no indications against this treatment, although in childhood and in the unmarried for obvious reasons it should, if possible, be avoided. From disobeying orders I have a few times seen metritis set in, temporary in its character and easily amenable to treatment ; a death I have never had. Finally, I contend that the mechanical treatment of displacements or dislocations of the uterus is in due accord with the principles observed in the treatment of dislocations and hernias elsewhere in the body, and that due regard is given therein both to the anatomy and physiology of the structures concerned, and therefore, as might be naturally expected, this treatment is both unfailing, safe, as well as lasting in its cure.

165 Collins-street, E.

4th January, 1889.

RUPTURED POPLITEAL ANEURISM.

By ALEXANDER MACCORMICK, M.D., HON. SURGEON, PRINCE ALFRED HOSPITAL, SYDNEY.

CHARLES JACOBSON, aged 48, married, a stevedore, was admitted into the Prince Alfred Hospital on January 26, 1889, suffering from a large swelling in the left popliteal region.

Patient is a well-built swarthy man, with a somewhat anxious expression ; hard working ; no history of syphilis.

The respiratory system is normal. The cardiac pulsation gives a heaving impulse to the chest wall. Capillary pulsation is distinctly visible. The radial arteries are thickened and cord-like, the pulse marked by collapsing. Apex heart is to be felt below and a little outside the nipple. The cardiac dulness is increased to the left. At apex first sound is muffled and loud ; second, blowing and rather indistinct ; at base first sound replaced by a short and not very loud murmur ; second, by a loud rasping murmur conducted down the sternum.

Patient states that towards the end of October last he was engaged in heavy work, principally lifting heavy weights, and whilst at work he strained himself, causing a small lump about the size of a pigeon's egg to appear at the back of the knee. He still went about his work, and he noticed that the lump gradually increased in size until it reached the size of a fowl's egg, when suddenly it increased rapidly and got intensely painful. The whole leg became swollen and he was unable to get about.

On admission there was a large pulsating swelling at the back of the left knee-joint and extending upwards along the back and inner aspect of the thigh. Auscultation elicited a distinct bruit in this swelling, and the patient complained of excruciating paroxysmal pains in it.

January 26.—An incision about four or six inches long was made over the inner aspect of the swelling in the line of the anterior border of the sartorius muscle, after applying a tourniquet to the upper part of the thigh. This laid open a large space which contained over a quart of coagulated blood. The incision having been enlarged a little upwards a little careful dissection isolated the femoral artery at the lower end of Hunter's canal, where it was found to be healthy, and was carefully ligatured. A small longitudinal slit was then made in the artery below the ligature and a fine probe introduced, which on being pushed downwards displayed a large oval opening on the popliteal surface of the artery just behind the centre of the popliteal surface of the femur. After carefully sponging away all blood-clot the remains of an aneurismal sack could be detected spread out from either side of the artery, so that it must have ruptured towards the bone ; the sack, if intact, would be about the size of a hen's egg. A sound was introduced downwards through the opening in the artery so as to facilitate the isolation of this part of the artery, which was then ligatured. The tourniquet was then removed and no bleeding took place.

The tissues on the outer side having been punctured with a knife above the level of the tendon of the biceps, a drainage tube was introduced ; then the whole cavity was well washed clean of blood clot, and the incision closed. The strictest aseptic precautions were observed throughout the whole operation.

The skin incision healed by the first intention, and the drainage tube track closed towards the fifth week.

Patient complained of a peculiar numbing pain in the leg during the first two days. The highest temperature recorded was 101° on the evening of the second day. The discharge at first

was abundant and consisted of blood and serum, which gradually lessened, and had the appearance of turbid serum.

Casually an aneurism about the size of a small hen's egg was discovered in the right popliteal space.

March 21.—Right femoral was tied with strong catgut at the apex of the scarpa triangle, the wound was closed without any drain and healing took place by the first intention, but in a few days the pulsation in the aneurism returned slowly and flexion was attempted, but owing to family troubles the patient left the hospital without submitting to further treatment.

August 21, 1889.—Re-admitted. The enlargement and pulsation on the right side became gradually more marked after leaving the hospital, but he felt hardly any pain in the part till four days before admission, when the pain gradually increased and now became intense. The aneurism seemed to increase towards the inside of the limb and became very hard.

On admission he was suffering intensely and was unable to sleep.

The femoral artery could be felt pulsating distinctly in Hunter's canal.

August 23.—The right femoral artery was ligatured low down in Hunter's canal with strong silk, and the wound completely closed, which healed without suppuration.

September 11.—Patient was discharged cured.

January, 1890.—Patient reported himself. He was then suffering from symptoms of angina pectoris. He had complete use of both his legs. On the right side there was a small hard lump in the region of the former aneurism. The tissues in the left popliteal space were pliable, there was no swelling of any kind, nor thickening of tissues.

Remarks.—The incision along the inner side of the thigh in the treatment of the aneurism on the left side had a double advantage.

1.—The artery was reached from the inner and posterior aspects, so that there was little trouble in separating it from the popliteal vein. The forcing of the structures away from the bone by the aneurism itself facilitated this.

2.—The healthy part of the vessel in Hunter's canal could be reached with little trouble.

After the first operation on the right side, I am forced to admit that the artery became again completely patent, although the ligature was tied tightly so to make it sink into walls of the vessel.

For the foregoing notes I am indebted to Mr. Higgins.

MR. BRUCK, has received a fresh supply of New Zealand Calf Lymph, at 2s. 6d. per tube, well filled.

PROCEEDINGS OF SOCIETIES.

SOUTH AUSTRALIAN BRANCH OF THE BRITISH MEDICAL ASSOCIATION.

MONTHLY meeting held at the Adelaide Hospital on February 27, 1890. Present:—Dr. Cleland (President), in the chair; Drs. J. Davies Thomas, Mackintosh, Giles, Symonds, Hayward, Swift, Cookson, Gault and Hamilton.

Minutes of the last meeting, held in November, 1889, were read and confirmed.

An apology was received for the non-attendance of the Hon. Sec.

Dr. GILES showed a case of curious deformity; also a case of amputation of fingers which exhibited some points of interest.

Drs. PERKS, GREGERSON and LYNCH were balloted for and declared duly elected.

Dr. GILES read a paper on two cases of Knee-joint disease, as follows:—

SURGICAL NOTES.

BY W. ANSTAY GILES, M.B. AND C.M., ED.,
ASSISTANT SURGEON TO ADELAIDE HOSPITAL, &c.

Two cases have recently been treated by me in the Adelaide Hospital with very gratifying results, and I thought a few remarks about them would not be uninteresting. They illustrate admirably the safety and success with which the knee-joint may be opened, provided most careful antiseptic precautions are adopted, and I will produce them simply as additional examples of operations rendered safe by Sir Joseph Lister's system of treating wounds.

The first patient I wish to bring before you is a boy who had a movable body in the left knee-joint for years, the result being that he was constantly incapacitated, and suffered considerably from recurring attacks of acute synovitis. After operation a typically aseptic course was maintained exactly as described by Mr. Watson Cheyne in his work on Antiseptic Surgery. His words are:—"As the result of these operations the discharge becomes very slight after the first 24 hours. There is no pain or swelling, in fact no local inflammatory disturbance whatever, and therefore, of course, no suppuration. Constitutionally the patient remains quite unaffected; he feels well, eats well, sleeps well, and in fact thinks it a great hardship to be kept in bed for a few days." This is just as things should be. Still we do hear of the converse occurring, even when every possible precaution is taken by the most careful and scrupulously exact operating surgeons. No one in our Hospital carries out the antiseptic principles in every minute detail with greater

thoroughness than Dr. Stirling, yet most of us will remember the case he read before this Society last year of the removal of a loose cartilage from the knee-joint, the result of which interference was most disastrous. In this connection it might be interesting to mention the collection of cases compiled by Benndorff in 1867, which shows that among 218 direct operations for loose bodies in the knee-joint he found 41 fatal cases, or about 18 per cent.; and contrast this with Volkmann's Statistics, who, in 1881 had opened non-suppurating knee-joints over 200 times without one bad result after adopting the antiseptic methods.

Though the knee-joint is the one in which loose bodies are most frequently discovered, they are also found in the elbow-joint and other joints of the body. The number of these bodies is subject to great variety, and depends upon their origin. Sometimes they may resemble the melon-seed bodies found in enlarged and chronically inflamed bursae. A few years ago Mr. T. Smith, of St. Bartholomew's Hospital, London, removed 415 bodies from a knee-joint; all were about the size of large peas and composed of hyaline cartilage; only five or six were attached, the remainder were entirely free in the synovial cavity.

Allow me to briefly enumerate the causes of loose bodies in joints.

1. A thickened or indurated synovial fringe which has become pedunculated and perhaps detached.

2. Masses of fibrine condensed and roughly pressed into shape.

3. Blood effused into a synovial fringe may become organized and form a pedunculated body which, when its stalk gives way, falls loose into the joint cavity.

4. A piece of cartilage or cartilage and bone may be chipped off and fall into the joint.

5. Pieces of articular cartilage may exfoliate after injury.

6. Nodules of fibro-cartilage may arise from the cartilage cells found in the villous processes of the synovial membrane.

7. A detached osteophyte.

8. The point of a broken needle has been found embedded in a loose body removed from a joint.

In my opinion the piece of cartilage I now exhibit will come under the sixth division in the above list.

A. B., æt. 20, a harness maker, residing at Woodside, was admitted into the Adelaide Hospital on the 11th January, 1890, complaining of pain in the left knee.

History.—Has had pain in this joint for 10 years, and is frequently obliged to lie up on account of great pain and swelling in the joint.

Does not remember ever having met with an injury of any kind. The pain is of a gnawing character, not worse at night. There are no starting pains. About three weeks ago, while in bed, he heard something crack, and after this the limb assumed a position of flexion, which gradually passed away. Previous health good. Family history good.

On examination.—The left knee-joint is fuller and rounder than that of the other side. No floating of the patella. Fluctuation is very distinct above and below the patella. There is a crop of papules over the joint, the result of applications of mustard plasters, otherwise the skin is healthy in this region. On the outer side of the extensor tendon, just above its insertion into the patella, a movable body about three-quarters of an inch in diameter can be felt, which slips readily into the supra-patellar pouch but can be easily brought out again by manipulating the joint.

After keeping the limb perfectly at rest for a few days in order that some of the fluid might be absorbed, I decided to remove the offending substance by direct incision. The night before the date fixed for operation the patient had a bath; the limb was most carefully cleansed and the knee enveloped in a towel soaked with corrosive sublimate lotion (1 in 3,000), a waterproof sheet surrounding this. The next morning (22nd Jan.) the limb was thoroughly washed with ether and corrosive sublimate lotion; after this the loose body was brought to the surface and harpooned with a sharp needle which fixed it admirably. Ether was then administered by Dr. Lynch and I made an incision about three inches in length in the long axis of the limb, over the spot where the body was anchored. As soon as the capsule was opened freely the loose body was squeezed out without the least difficulty, and proved to be the piece of cartilage I have shown you. I did not put any sutures into the capsule, nor did I think it necessary to employ a drain, as the bleeding was insignificant and the tissues had been very little handled. The edges of the wound were accurately brought together with horsehair, iodoform was dusted over its surface, and after a layer of gauze had been applied a sponge was placed over the incision with a thick dressing of sal alembroth gauze and wool bandaged outside this, so that very firm pressure could be maintained. The limb was put up on a back splint.

On the 27th January the wound had firmly united, and the stitches were removed. There was no sign of discharge of any kind, nor had the patient complained of the slightest pain since the operation. The splint was discarded.

29th January.—He was allowed up, and went out into the garden on crutches.

About this date an erythematous rash suddenly made its appearance and covered the joint, but was unaccompanied by any constitutional symptoms, nor did he complain in consequence. After being out about twenty-four hours it rapidly faded away. The wound was not being dressed with any antiseptic at the time, so the eruption could not have been caused by any antiseptic application. On account of this we kept the patient at rest longer than we otherwise should have done, and did not allow him to walk about till the 5th February, when he got up, moved with perfect comfort, the knee-joint bending with ease to its fullest extent and not the slightest pain nor inconvenience was complained of. The next day he was discharged, and I have asked him to attend to-night in order that you may see the result.

My second case is interesting for two reasons:—The first being that a knee-joint full of pus was freely opened and two large drainage tubes passed through it without the slightest complication following. All suppuration rapidly ceased; within three weeks the wound had healed and the joint, though thickened and stiff, was quite free from fluid. Soon after this passive movements were regularly carried on, and in three weeks after this the man was able to bend his knee-joint to a right angle. To-night you see him walking erect without any support, and the comparatively trifling limp now present is daily becoming less noticeable. The second point I would draw your attention to is the infrequency of suppuration spontaneously occurring in a joint affected by gonorrhœal rheumatism. I cannot explain its presence in this instance; still the fact remains that it did occur, and the joint, in my opinion, was saved by prompt interference.

The notes I have are as follows:—

G. D., æt. 24, Packer in a tobacco factory, was admitted on the 16th December, 1889, into the Adelaide Hospital with the following history:—He has been unwell for some time, and during the past fortnight the left knee has become exceedingly swollen and painful. He has had gonorrhœa for two months. This had almost disappeared when he got a chill after a hard day's work, and this was followed by pain in the arms and legs. The pain lasted two days, when it disappeared from all parts of the body except the knee, and this joint continued to be very painful.

His present state.—He cannot sleep at night, sweats profusely, is very emaciated, and looks pale and miserable. At present no urethral discharge. A No. 11 catheter can be passed with ease. The organs of the body are healthy. Some constipation is present. The joint is enlarged and fluctuating, extremely painful when moved, but

the skin over it is not reddened nor do any of the other joints appear to be involved.

Treatment.—To be kept in bed. Cathartics internally.

About the 26th Dec. the urethral discharge has reappeared with an exacerbation of the knee symptoms.

28th Dec.—The fluid in the joint has increased, the pain is more intense than ever, and all the evidence is in favour of pus in the joint. A fine aspirating needle was employed and pus was discovered.

30th Dec.—After the limb had been prepared, as described in the preceding case, the patient was etherized, and two incisions were made into the joint, one on the inner, the other on the outer aspect, and a large quantity of pus escaped. The finger was then passed into the joint, and the articular cartilages were examined, but appeared to be quite smooth and healthy. Each incision was about three inches long. The joint was thoroughly irrigated with corrosive sublimate lotion, and two large drainage tubes were put right through the upper and lower parts of the cavity. The dressing employed was sal alembroth gauze and wool, and the limb was placed on a McIntyre's splint.

2nd Jan., 1890.—The tubes were divided and shortened. Hst. cubæ co. internally.

5th Jan.—Dressed; wound looking healthy. Tubes gradually being shortened, and the discharge is rapidly diminishing.

9th Jan.—The tubes left out. The patient is gaining flesh and the wounds are rapidly healing. He sleeps well at night, has no pain, and the urethral discharge is very slight.

16th Jan.—Limb put up in plaster-of-Paris, with an interruption at the knee and a posterior splint. The wounds are two granulating surfaces. There is no discharge from the joint. He goes about on crutches.

20th Jan.—Wounds are healed. The patient is every day gaining flesh and strength. No farther note has been taken, but soon after this date the plaster-of-Paris support was dispensed with, and passive movements, with massage, commenced. He is now virtually cured, and his limb is as good and useful as ever.

I must thank Dr. Lynch, one of our house-surgeons, for his notes and for his care of these cases during treatment.

A discussion took place in which Drs. THOMAS and HAYWARD took part.

Dr. THOMAS took exception to Dr. Giles' statement as to the rarity of suppuration in the knee-joint following gonorrhœal rheumatism; in his experience it was not an uncommon occurrence.

Dr. HAYWARD's experience coincided with Dr. Giles' rather than with Dr. Thomas'. With regard to the removal of loose cartilages from the knee-joint he thought that the element of danger in opening the joint was rather greater than might be inferred from Dr. Giles' paper. He related two cases that had come under his observation where the operation had been attended with far from favourable results, though they had been performed by skilful operators with strict antiseptic precautions. In one the patient died two days after the operation was performed, and in the other a stiff joint resulted.

Dr. GILES, in reply to Dr. Thomas, adduced authorities supporting his contention that suppuration following gonorrhoeal rheumatism was rare, and, referring to Dr. Hayward's remarks, he said that he had no desire to infer that the opening of the knee-joint was unattended with risk.

NEW ZEALAND MEDICAL ASSOCIATION.

THE fifth annual meeting of the New Zealand Medical Association was held in the Dunedin Town Hall on Wednesday, February 19th, and following days. Dr. Hocken, the president, occupied the chair, and there were also present:—Drs. Coleman, Hacon, Cressey, Whitton, Lewis, Purchas, Batchelor, Maunsell, Brown, Colquhoun, Christie, Will, Copland, De Zouche, Syme, Lindo Ferguson, Morton, Von Mirbach, Trevor, King, Knight, G. Macdonald, and others.

In the afternoon DR. HOCKEN delivered the presidential address, in which he referred to the Medical Bill. He said the opposition to the measure was unfounded as the Bill was intended to be an advantage not only to the profession, but to the public at large. He also spoke on education, hygiene, registration, and suppression of quackery.

After the reading of the correspondence and the minutes of the last annual meeting, the members adjourned at 5.30 p.m. to meet again at 8 o'clock, when the following papers were read:—

Paper by DR. HACON, Christchurch—"History of the Propagation of Calf-Lymph in New Zealand;" also, Exhibits of Antiseptic Midwifery Appliances; also, Sequestrum from Os Calcis.

Paper by DR. BATCHELOR, Dunedin—"Statistics and Notes of a Series of Abdominal Sections;" also, 'Experiences in Apostoli's Method of Treating Uterine Fibroids,' with apparatus.

Paper by DR. TREVOR, Ashburton—"Two Cases of Suprapubic Lithotomy," with specimens.

Paper by DR. KING, Seacliff Asylum—"Peripheral Distribution of the Sensory Nerves."

Paper by DR. THOMAS, Christchurch—"A Case of Acanium, with Prolonged Gestation."

Paper by DR. KNIGHT, Auckland—"Intraperitoneal Rupture of Bladder;" also, "Notes on Some Cases of Hydatids and Empyema."

Thursday, February 20.

In the afternoon DR. HACON, of Christchurch, read a paper on the "Status of the N.Z. Asylum Physicians, and the necessity for making P.M. Examinations in Asylums," in which he made reference to the very few *post mortem* examinations made in the asylums of the colony and the tendency of the authorities to check any progress in that direction. He condemned the parsimony of the Government in not allowing the superintendents of the principal asylums to have medical assistants, and animadverted on the appointment of medical superintendents who have no practical training

in the care and treatment of the insane. He concluded by exhorting the association to bring the injustices of both the patients and the superintendents under the notice of the Government.

Remarks on Dr. Hacon's paper were made by several members, all agreeing with the burden of the opinions expressed in the paper. It was ultimately decided to appoint two members as a committee to draw up a series of resolutions to be brought before the association on the following day, to be adopted and forwarded to the Government.

The discussion on the Medical Bill, introduced by Dr. DE ZOUCHE, was postponed till next night.

An adverse opinion was expressed on the practice of the Government in paying public examiners 10s. 6d. on policies of £100; but medical action was left to the discretion of each branch.

In the evening the following papers were read:—

Paper by DR. COLLINS, Wellington—"A Case of Cerebral Tumour."

Paper by DR. MAUNSELL, Dunedin—"A New Method for Excision of the Tongue."

Paper by DR. MACKENZIE, Wellington—"A Case of Mastoid Disease." (Operation, Recovery.)

Paper by DR. LINDO FERGUSON, Dunedin, and DR. MACKENZIE, Wellington—"Notes and Statistics of the Common Accidents to the Eye in N.Z. practice."

Paper by DR. E. JENNINGS, Christchurch—"A Case of Abdominal Obstruction."

Paper by DR. LEAHY, Ashburton—"Notes on two Cases of Suturing of the Patella."

Friday, February 21.

DR. TRUBY KING replied to the statements of Dr. Hacon with regard to asylums. He said that at Wellington *post mortem* examinations were held in all necessary cases, and also at Seacliffe. As to assistant superintendents, the Inspector-General had recommended that one be appointed at Seacliffe, and this had been officially authorized. Dr. King showed that it had not been the practice to appoint superintendents without previous experience.

The Medical Bill was considered, and a resolution was passed reaffirming its principles, and trusting the Government would see their way to pass it.

A discussion took place on the method of electing members who move from one province to another, and also on the representation of the Otago University in electing the honorary medical staff of the Dunedin Hospital.

In the evening the following papers were read:—

Paper by DR. FELL, Wellington—"The Quarantine Regulations of the Ports of New Zealand;" also, "An Account of a Case of Raynaud's Disease."

Paper by DR. COLQUHOUN, Dunedin—"Pernicious Anaemia;" also, "Notes on a Case of Cerebral Tumour."

Paper by DR. OGSTON, Dunedin—"The Public Health Laws of New Zealand."

Paper by DR. MAUNSELL and COLQUHOUN, Dunedin—"An Unusual Case of Abdominal Section."

Paper by DR. GORDON MACDONALD, Dunedin—"Notes on the Cancer Statistics of New Zealand."

The Annual Dinner on Saturday evening, February 22, concluded the fifth annual meeting of the N.Z. Medical Association.

MR. BRUCK begs to call the attention of the profession to his extensive assortment of the *latest medical works, published both in Great Britain and America*. A list of some of the books in stock will be found in this issue.

NOTICE.

The Editor will feel obliged by any gentleman, who wishes to ventilate any subject of professional or public interest, writing an editorial or leading article on it, which if found on perusal to be consonant with the policy of the paper, will be inserted in an early number.

All communications intended for the Editor should be sent to the 'A. M. Gazette' Office, 35 Castlereagh Street, Sydney.

** * Contributors can have their Papers reprinted and published in Pamphlet form, at Cost Price, if the necessary instructions are given to the Publisher at the same time the contributions are sent in.*

AUSTRALASIAN MEDICAL GAZETTE.

SYDNEY, MARCH 15, 1890.

EDITORIALS.

"DR." WILLIAM NICHOLAS RICHARDS.

WE earnestly call the attention—not so much of our professional readers as of the editors of the lay Press to whom this number is specially sent—to the correspondence we here reprint, the originals of which are in our possession:—

DR. RICHARDS

No. 7 Spring st., off Pitt
St., North Sydney

Dear Sir

I wish to Consult you on important Case and wish you to Give Me a Candid and a Straightward opinion and if you do not think You understand the Case do not take it in hands as i expect any Doctor that takes this Case in hands to effect a permanent Cure., A now My Dear Sir please, Let Me Know at your earliest opportunity if you Can do anythink for My Wife the following is her Symptoms

- 1 dreadful headaches and drowsiness during the day
 - 2 Giddiness irregularity of Bowels
 - 3 discontentedness and Low Spirited
 - 4 Weakness pain in the Back
 - 5 Buzzing noises ears and head
 - 6 a fear of Something dreadful is about to happen
 - 7 hasty uncontrollable Temper and Sometimes fullness of Chest after Meals
- Last of all her Monthey Courses Stopes on three or 4 Weeks at a time and She Gets very Weakmindid So now i told You all particulars Writ Soon and Let me Know if you Can do any thing for her, I am Dear Sir
Yours Faithfully

CHARLES KEENAN.

I wish the confidence of my patients, and as I am well aware that there are many unscrupulous persons practising illegally, I would deem it a favour should any of my patients receive letters or circulars without having first written to the sender, if they would kindly inform me of the fact and forward such communication with their letter.

It is not beneath my dignity to ask all persons who intend to consult me, either personally or by letter, to

see the register of medical practitioners (to be found at all police stations and large chemists' shops).

If you will favour me by so doing you will find that I have held an honourable position as a duly qualified medical practitioner for many years.

(Dictated.)

Office of Dr. Richards, 7 Spring Street (off Pitt Street),
Sydney, 22nd No. 1889.

MR. C. KEENAN

My dear sir

I am in receipt of your esteemed communication wherein you describe symptoms which prove beyond the shadow of a doubt that your wife is not only troubled with Nervous debility but also with spermatorrhœa the latter is indeed a most serious complaint and one which if allowed to run on untreated will certainly result disastrously, she will eventually become unable to pass her urine, without undergoing an operation which is not only exceedingly dangerous but only too frequently results in death. Do not allow the foregoing plain language to unnerve her for I can furnish her with remedies which will cure her thoroughly and permanently in a reasonable length of time. My terms for the successful treatment of your wife's complaint are first month 100/-, second month 70/-, third month 55/- or if the entire course of treatment is taken at the one time she can save in postage labour package &c. 25/- viz. if she orders the entire course of three months treatment at the one time it will cost her but £10. I will say in passing that it would be better to order the entire course of three months treatment at the one time as it is necessary to stop the distressing and dangerous losses which are constantly occurring internally and while at stool and urinal. While taking this course of remedies she will notice a change for the better during the first two weeks and a permanent cure will ultimately follow. Her system will begin to recuperate and she will soon be in full vigor and health again. Now my dear sir I would advise your wife not to delay in this matter for "procrastination is very dangerous." I sincerely trust she will appreciate my motives for thus advising her for when I see a lady stricken with that dread complaint I cannot help rushing to the rescue. I shall prepare her remedies at once and will send them immediately on receipt of her post office order. Trusting your wife will remember as I said before "delay is dangerous" and hoping to hear from you again soon.

I remain dear sir

faithfully yours,

W. N. Richards.

Pr. D. S. M.

N.B.—Always send Stamps for reply, and send full address in each letter.

This is doubtless but a sample of what occurs almost hourly in New South Wales as a result of the defective state of the law regulating the practice of medicine, but it is only rarely that examples fall into the hands of individuals in a position to give them publicity.

The writer of the first letter is evidently an uneducated man who, anxious as to the health of his wife, was induced to communicate with the advertiser by the glowing announcements published so freely by the newspapers in Australia of "Dr. Richards, the eminent specialist," who "has devoted a lifetime to the study of private, nervous

and skin diseases." "Should you require medical treatment, as procrastination is sometimes dangerous, it would be advisable for you to sit down quietly in your chamber and write to the Doctor, detailing every experienced symptom," &c., &c., &c.

The above extracts are made from a number of the *Sydney Daily Telegraph* of recent date. Comment on the reply of this "eminent specialist" is unnecessary, except to call attention to the remarkable circumstance that he, on consideration of the symptoms, finds without "the shadow of a doubt" that the sick woman was troubled with *Spermatorrhœa*. For the information of our lay readers we may say this is a disease which can only occur in a male and which is physically impossible in a female. It is obvious from the absurdity of this statement that the letter, though it professes to have been dictated by Dr. Richards, could never have been even seen by him, but must have been written by some ignorant layman. For no man who at any time possessed sufficient knowledge of anatomy and physiology to have passed the examinations of the College of Surgeons could have, even by inadvertence, been led into making so ludicrous a diagnosis. Under these circumstances what can be thought of the demand from a poor man of at least £10 to cure his wife of a disease she, on account of her sex, could not possibly have? And what remedy is open to the public against such gross imposition, instances of which must still be occurring, for similar advertisements are daily appearing, and it is obvious that they would not do so did not the expenditure result profitably to their authors. It may be well here to say who and what "Dr. Richards" was and is. He was admitted a Member of the Royal College of Surgeons of England on the 14th of May, 1838, and this diploma was registered in New South Wales on the 4th of January, 1858, since which date he has resided and practised in Newcastle, Scone, Murrumbidgee, Armidale, Glen Innes, Inverell, Grafton, Casino, Tamworth, Gunnedah, Narrabri, Brewarrina and other places in that colony. About 1885 advertisements began to appear purporting to relate to him, notifying "to sufferers of both sexes that he had permanently established himself in Sydney." On the 5th of May, 1887, he was examined before the Select Committee of the Legislative Council of New South Wales. On being questioned by the chairman, he, on the ground that his answers might render him liable to criminal proceedings, refused to state whether the advertisements in the newspapers headed "Dr. Richards, M.A. Oxon., M.R.C.S. Eng." were his, how long he had been practising in Sydney, whether he was practising on his own

behalf or as the employé of a firm, Messrs. Buckridge and Browning; he also declined, on the same plea, to say whether he was personally acquainted with these persons. Each of whom, however, when subsequently examined, admitted that they were most intimately connected with him—Roland Buckridge, who said he was a general agent, in keeping his books and arranging his monetary affairs, and C. J. Browning, accountant, as professional assistant in attending to patients and in the business generally. The latter, at all events, has a lucrative post, being the owner of numerous valuable trotting horses, and maintaining an extensive and comfortable private establishment. However, the conduct of this philanthropist having been brought under the notice of the Council of the College of Surgeons, "Dr." William Nicholas Richards was, on the 10th of November, 1887, a few months subsequent to his examination before the Select Committee, removed from being a member of that College, since which time he has been without a medical or surgical diploma. Nevertheless, he is still upon the register of medical practitioners of New South Wales, a fact to which he calls attention as a proof of his trustworthiness, as will be seen in the heading of his letter to Keenan, printed above. We presume that he is so, because the Medical Board of New South Wales believes it has no power to remove any man from the medical register of that colony who has once been placed upon it, or it would surely have removed the name on receipt from the College of Surgeons of information as to the cancellation of the only diploma in virtue of which he had been registered. This has, however, never been authoritatively decided, and we think that had the Board a fitting sense of its responsibility to the public it would remove W. N. Richards' name, leaving him to move in the Supreme Court to show that it had acted beyond its power. It is positively indecent that such a man, or those who employ him, should be able to refer to the official gazettes kept at the various Government offices for confirmation as to his good standing as a medical practitioner. What are the functions of a Government if not to introduce such legislative measures as will protect the people whom it governs from continued misrepresentation and fraud. With the report of the Select Committee of 1887 in existence, no one can say that there is not absolute proof of the necessity for legislation or that a Government which neglects to give effect to its recommendations is not culpably indifferent to its duty. That this is not merely our opinion is shown by the letter sent to the Premier (Sir Henry Parkes) in 1887, signed, amongst other representative men, by Sir Alfred

Stephen, Lieutenant-Governor, Sir Frederick Darley, Chief Justice, His Eminence Cardinal Moran, and the late Primate, Dr. Barry, in which they say: "The terrible evils consequent upon this state of the law have been so forcibly brought under our notice by the publication of the evidence given before the Select Committee of the Legislative Council that we feel it but a duty incumbent on the occupants of the offices which we hold to make representations of the urgent necessity for such prompt legislative action as will remedy them."

Will the Government act? If so, when? If not, what more evidence of the necessity for action does it want? Has the neglect hitherto been the result of negligence on the part of the Ministry collectively or of an individual Minister?

FEDERAL QUARANTINE AND REGISTRATION.

THE intercolonial conference recently held in Melbourne would have been a good opportunity for the discussion of Federal Quarantine. One member of the conference, the senior representative of South Australia, Dr. Cockburn, is a member of our own profession. Is it asking him too much if we urge upon him the necessity to use his influence and talents to prevent this subject from being further shelved? Over and over again have we brought it before the profession, but not one single step has been taken in the matter, indeed we are afraid that even yet we shall have the miserable satisfaction of being able to say "We told you so," after some such fell disease as small-pox, cholera, or yellow fever has rooted itself in Australia. Not once, but many times have we suggested Federal Quarantine as the sole sure preventative against the introduction of infectious disease, but let us impress upon any who reads this article and who, wishing to see zymotic diseases kept from the colonies, has the influence, to use it in establishing Federation as regards quarantine. In previous articles it has been shown what are essentials as regards this matter, and should anyone wish to know further as to our ideas on this subject we shall be happy to answer any questions.

We have brought before the profession the subject of Federal Registration; may we also call Dr. Cockburn's attention to our views expressed in July last, as follows:—

"We cannot refrain from expressing most strongly our conviction that registration in any one colony should suffice for the whole of Australia, and that the sooner Federation in this respect takes place the better for all concerned. It is absurd that each colony should, by varying slightly

the terms of their Registration Acts, place obstacles in the way of legally qualified men exercising their profession in the colonies generally, since by so doing they place them on a footing with quacks, to the benefit of the latter; for neither being registered, they are legally equal, with advantage to the quack, who will be less scrupulous in his dealings. To sum up, the situation calls for an increased standard as to diplomas eligible for registration, combined with federation." We see no reason to depart from this position, and we feel sure the majority of our professional brethren are with us in asking for Federal Registration. There is yet another topic which an intercolonial conference might discuss with benefit to our profession and to the public, that is a Federal Medical Council. This is no new idea, and so lately as November, 1889, we wrote as follows:—

"We would urge that a Federal Medical Council be appointed who should possess the power not only to register properly qualified men, but to remove such names from the register for unprofessional conduct or advertising. In short, a body similar to the Medical Council of Great Britain, but with increased local power. This Australian Medical Council would naturally have representatives in every capital who would investigate local cases and report to the whole body. *Not only could registration be carried on by this council, but other functions, such as the arrangement of quarantine, could be discussed and instructions given in case of infectious disease appearing in our midst.*"

Here again we see no reason to modify our opinions, and we would, in conclusion, as representing a large proportion of the medical men in Australia, ask that Federation as regards Quarantine and Registration of Medical Degrees form a topic of discussion at an intercolonial conference.

THE BATHURST HOSPITAL IMBROGLIO.

As the Bathurst Hospital imbroglio has now come to a satisfactory termination by the departure of the Resident Medical Officer and the re-appointment of the Honorary Medical Staff and the matron and nurses, who had resigned because they were unable to work in any way with that official, we think it opportune to make some comment on the circumstances. Both staffs declined to give any other reason for their resignation than that they found it impossible to continue to occupy their positions with advantage to the institution so long as the Resident Medical Officer (Wm.

Fry Garrett, L.R.C.P.S. Ed., L.F.P.S. Glas.) was retained in it. When asked by the committee of the Hospital to state the particular causes which induced them to make so emphatic a protest of disapproval of the conduct of this person they refused, alleging as their reason that with the example of the Orange Hospital before them, in which Dr. Goode, when making specific charges against a hospital official (the matron) in what he believed to be the interests of the patients, was subjected to the worry and anxiety of continued libel actions, resulting in a pecuniary loss of some thousands of pounds and winding up with imprisonment, they did not feel justified in laying themselves open to the same risk.

How much the public interest as regards hospitals generally has suffered by the result of the actions against Dr. Goode is shown by the Bathurst incident, which is in all probability but the precursor of others to come.

Dr. Garrett's career in Bathurst had a somewhat sensational wind-up in a series of police court proceedings at that town on February 18th last. The first case was a charge of assault brought by him against Mr. Avery, a local chemist, who had knocked the complainant down. This was dismissed, for, though the doctor was knocked down, the Bench were of opinion there had been "no assault in law" committed. Another was a charge of assault by Mr. Avery against Dr. Garrett for assault, which was also dismissed. In the third Dr. Garrett was charged under the Vagrant Act with using language of an improper character in a public place, and for this he was convicted and fined the highest penalty—viz, £5 and costs, or, in default of payment, a month's imprisonment.

VON MIRBACH *v.* McHARDY AND OTHERS.

A CASE, tried before His Honor Chief Justice Prendergast at the Supreme Court, Napier, N.Z., on October 1 last, which resulted in a verdict for the plaintiff of £251 with costs upon the medium scale, was again before the Full Court at Wellington on February 2 last at the instance of the defendants, who had applied for a new trial. This was refused with ten guineas costs.

The action was brought by the plaintiff, who is an M.D. of Munich practising at Waipawa, against the proprietors of the *Waipawa Mail* for libel contained in a letter published by them which denied that Dr. Von Mirbach was

entitled to be called Dr., and also comparing him to Shylock. We have carefully read the evidence adduced at the trial, and have been forced to the conclusion that a more unjustifiable libel was never committed, or one in which the animus consequent on petty business disappointment was more apparent. We congratulate Dr. Von Mirbach on the result of the action, and consider that in taking proceedings he not only acted for his own protection, but has aided in upholding the dignity of medical men generally.

THE TENTH INTERNATIONAL MEDICAL CONGRESS.

WE, as representative of the profession in Australasia, have received the following communication from the general committee of the "Tenth International Medical Congress" to be held in Berlin, in August, 1890. As the most effective means of extending the invitation so fraternally given to the Medical men of these colonies, we now republish it with the essential portions of the rules and programme.

INVITATION TO THE TENTH INTERNATIONAL MEDICAL CONGRESS.

In accordance with the decision of the Ninth Congress at Washington, the Tenth International Medical Congress will be held at Berlin from the 4th to the 9th of August, 1890.

By the delegates of the German Medical Faculties and the chief Medical Societies of the German Empire, the undersigned have been appointed members of the General Committee of Organization. A Special Committee of Organization has also been appointed for each of the different sections, to arrange the scientific problems to be discussed at the meetings of the respective sections. An International Medical and Scientific Exhibition will also be held by the Congress.

We have the honour to inform you of the above decisions, and at the same time cordially to invite your attendance at the Congress. We should esteem it a favour if you would kindly extend this invitation to your friends in Medical circles.

We beg to accompany our invitation by a copy of the Statutes and Programme, as also by the List of the intended sections and their Special Committees of Organization.

Dr. Rudolf Virchow, President; Dr. von Bergmann, Dr. Leyden, Dr. Waldeyer, Vice-Presidents; Dr. Lassar, Secretary General.

REGULATIONS AND PROGRAMME.

The Congress shall consist of legally qualified Medical men who have inscribed themselves as Members, and have paid for their Card of Membership. Other men of science who interest themselves in the work of the Congress may be admitted as Extraordinary Members.

Those who take part in the Congress shall pay a subscription of 20 Marks (One pound stg. or \$5) on being enrolled as Members. For this sum they shall

receive a copy of the Transactions, as soon as they appear. The enrolment shall take place at the beginning of the Congress. Gentlemen may, however, be enrolled as members by sending the amount of the subscription to the Treasurer, (Dr. M. Bartels, Berlin SW., Leipziger-strasse 75) with their name, professional status and residence appended.

The work of the Congress will be discharged by eighteen different Sections. The members shall declare upon enrolment to which Section or Sections they intend more particularly to attach themselves.

At the first meeting of each Section a President and a certain number of Hon. Presidents shall be elected; these latter shall conduct the business of the Sections in turn with the Presidents.

On account of the different languages employed, a suitable number of Secretaries shall be chosen from among the foreign Members. The duties of the foreign Secretaries shall be confined to the sittings of the Congress.

The Congress will assemble daily, either for a General Meeting or for the labours of the different Sections.

The General Meetings will be held between 11 and 2 o'clock. Three such meetings will take place.

The time for the sittings of the various Sections will be fixed by the Special Committee of each Section, it being understood, however, that no such sittings are to take place during the hours allotted to the General Meetings.

Joint sittings of two or more Sections may be held, provided that the Bureau of the Congress can offer suitable rooms for such sittings.

The General Meetings shall be devoted to—(a) Transactions connected with the work and general management of the Congress. (b) Speeches and communications of general interest.

Addresses in general sittings, as well as in any extraordinary meetings which may be determined upon, can only be given by those who have been specially requested by the Committee of Organization.

Introductory addresses in the Sections must, as a rule, not exceed twenty minutes in length. In the discussions no more than ten minutes are allowed to each speaker.

The official languages of all the sittings shall be German, English, and French. The Regulations, the Programme and the Agenda for the day will be printed in all three languages.

Medical Students, and other persons, ladies and gentlemen, who are not Physicians but who take a special interest in the work of a particular sitting, may be invited by the President or be allowed to attend the sitting by special permission.

Communications or enquiries regarding the business of separate sections must be addressed to the managing members thereof. All other communications and enquiries must be directed to the General Secretary, Dr. Lassar, Berlin NW., 19 Karlstrasse.

At the meeting of the Medical Board of Victoria held last month Miss E. Constance Stone was registered as a medical practitioner, being the first Australian lady doctor who has been granted registration in the Australian colonies. This young lady, whose parents reside in St.

Kilda (Melbourne), left there some six years ago to follow out a course of medical study. This was necessary at the time, as no opportunities were then afforded to ladies to prosecute medical studies in our Universities. Dr. Constance Stone first graduated at Philadelphia, obtaining the M.D. degree, and after being assistant medical physician at the Women's Hospital, Staten Island, New York, she proceeded to Canada, and at Toronto obtained her M.D. and C.M. degrees. She next sailed for England, and succeeded in obtaining the L.S.A. diploma, after which she was physician's assistant at the New Hospital for Women, London. Her medical studies covered a period of six years.

We heartily congratulate Dr. Constance Stone on her being the first lady registered as a medical practitioner in Australia, and wish her the highest success, both pecuniary and social, in her professional career now commencing.

LETTER TO THE EDITOR.

A QUERY.

(To the Editor of the A. M. Gazette).

SIR,—A. is a L.A.H.I., registered in Great Britain and Ireland 1877, and in this colony 1886, and therefore a Legally Qualified Medical Practitioner. B. is a L.S.A. and M.R.C.S.E., Government Medical Officer and Hospital Medical Officer for district D., where both reside. A. is in extensive practice and is also Medical Officer to the Oddfellows' Lodge in D., and was formerly Government Medical Officer in another district. A. came to the district D. twelve months ago as Assistant Government Medical Officer during typhoid outbreak to B.'s predecessor, and finally settled down in D. four months before B.'s appointment to the hospital, for which A. did not oppose him. A. has been in practice for nearly thirteen years, and has met in consultation some of the leading men both at home and in the colony. B. has on two occasions met A. in consultation; one case was B.'s and the other A.'s. B. has brought his father-in-law, a feeble old man, to live with him, and since doing so persistently refuses to consult with A. Is he justified in doing so, A. never having committed a breach of professional etiquette?

Yours truly,
MEDICAL PRACTITIONER.

[Whether one practitioner shall meet another in consultation or not is a matter which can only be decided by the persons immediately concerned, and is governed by no law or even custom. In this case the relative value of the qualifications of A. and B. would seem to give fair reason to the latter for refusal, though he may have others of a private nature of which we are unaware.—ED. A. M. G.]

BOWRAL.—Dr. Wilson has superior accommodation for medical boarders.

OBITUARY.

J. HARRY POLAND.



It is with extreme regret that we record the death of James Harry Poland, M.R.C.S. Eng. et L.S.A. Lond. 1877, Dipl. Pub. Health R.C.S. Irel. 1889; Dipl. State Med. K.Q.C.P. Irel. 1889, who lost his life on February 28, in the wreck of the B.I. Co.'s R.M.S. "Quetta," which vessel sank in less than three minutes after striking an unknown rock in Torres Straits, about 20 miles from Thursday Island, on her voyage from Brisbane to London. The deceased gentleman, after obtaining his diplomas, acted as Demonstrator of Anatomy at Guy's Hospital, and in 1878 came out to Victoria. Soon after his arrival he was appointed Resident Medical Superintendent of the Bendigo Gold District Hospital, at Sandhurst. He afterwards practised at Maryborough (Vic.), and at Balranald (N.S.W.). In 1883 he removed to Rockhampton (Qu.), and two years afterwards he joined the Queensland Immigration Service, in which he continued ever since. It was Dr. Poland's intention that this should be his last trip and to retire from the Immigration service on the "Quetta's" return to the colonies, and then to settle in Sydney permanently. Dr. Poland was a gentleman of a genial disposition, and had abilities of a very high order; he was a fluent writer, and a frequent contributor to our columns. His wife, who was travelling with him, also perished, and both were buried on Aconith Island; on the top of their grave a board was placed, with the following words written upon it—"Here rests all that was mortal of Dr. Poland and also a passenger of the "Quetta," buried March the 4th, 1890. R.I.P."

BOOK NOTICES.

A HANDBOOK OF DISEASES OF WOMEN, INCLUDING DISEASES OF THE BLADDER AND URETHRA. By Dr. F. Winckel, Professor of Gynecology, and Director of the Royal University Clinic for Women in Munich. Authorized Translation. Edited by Theophilus Parvin, M.D., Professor of Obstetrics and Diseases of Women and Children in Jefferson Medical College, Philadelphia. Second Edition, Revised and Enlarged. With 152 Engravings on wood, most of which are entirely new. 766 pages. Philadelphia: P. Blakiston, Son & Co., 1889. Sydney: L. Bruck. (Price 12s. 6d.).

The first edition of this book appeared about two years ago, and the fact that a second edition is called for so soon is both a proof of its merit and a reason why an extended notice is not called for. The reputation both of the author and the translator is a guarantee of the excellence of the work, which we can conscientiously recommend as a text-book for students, as well as a work of reference for the practitioner.

INSOMNIA AND ITS THERAPEUTICS. By A. W. Macfarlane, M.D., Fellow of the Royal College of Physicians, Edinburgh; Fellow of the Royal Medical and Chirurgical Society of London; Examiner in Medical Jurisprudence in the University of Glasgow; Honorary Consulting Physician (late physician) Kilmarnock Infirmary; formerly Examiner in Medicine and Clinical Medicine in the University of Glasgow, &c., &c. London: H. K. Lewis, 1890. Sydney: L. Bruck (Price, 12s. 6d.).

The author fully discusses those affections which are found in practice to cause insomnia most frequently, and, briefly, some diseases selected from among those which more rarely produce sleep disturbance. There has also been introduced a chapter containing a *résumé* of some physiological facts concerning sleep, for the purpose of making clear the bearings and significance of its pathological disturbances. The subject throughout has been gone into in a very thorough and also readable manner. The arrangement is excellent, the language clear and unmistakable, the descriptions distinct, and the proposed treatment practical, sensible and scientific. The book, as a whole, is an admirable elucidation of a subject which receives but scant notice in any text-book on medicine.

A MANUAL OF INSTRUCTION FOR GIVING SWEDISH MOVEMENT AND MASSAGE TREATMENT. By Prof. Hartvig Nissen, Director of the Swedish Health Institute, Washington, D. C. With 29 engravings. Philadelphia: F. A. Davis, 1889. Sydney: L. Bruck (Price 5s.).

Numerous books on Massage have lately been published, but, in the opinion of the author, there are no manuals of Swedish movement and massage treatment in the English language which give any information how to apply the treatment in different diseases. To supply this want the author has published this little manual, in which he describes the most useful movements, many of these illustrated by woodcuts, and, in addition, he gives a list of various massage prescriptions for certain cases.

OUTLINES OF THE CLINICAL CHEMISTRY OF URINE. By C. A. MacMunn, A.M., M.D. With 64 Woodcuts and plate of spectra. London: J. & A. Churchill, 1889. Sydney: L. Bruck. (Price 9s.)

This is a well written book of 247 pages, containing a brief but accurate account of the Chemistry of Urine in health and disease. The directions for the different manipulations are clearly defined, and, in addition, an account is given of the more recent advances in the subject, mostly taken from German text-books not yet translated into English.

THE MONTH.

NEW SOUTH WALES.

THE Senate of the Sydney University have appointed the following examiners to act with the lecturers in connection with the forthcoming examinations in March:—*Clinical Medicine*, the Hon. Dr. Mackellar; *Clinical Surgery*, Dr. A. McCormick.

DURING last year in Sydney and suburbs there were 209 fatal cases of typhoid, 24 of scarlet fever and 183 of diphtheria.

THE steamer *Sikh* arrived in Port Jackson on February 23rd from Japan, China and Sourabaya with four cases of small-pox on board. She was quarantined.

THE number of patients admitted into the Sydney Hospital from January 1 to December 31, 1889, has been 3,083, an increase over the previous year of 33. Of these 1,765 were surgical and 1,318 medical cases; 2,175 were males and 908 were females. The largest number of admissions was in the month of January, 310; the smallest in the month of September, 189. The number of accidents and urgent cases admitted was 1,293. The number of accidents and urgent cases attended to by the resident medical staff but not admitted has been 3,904. The number of patients treated at the outdoor ophthalmic department for the year ended December 31, 1889, has been 512; at the ear, nose and throat department, 266; at the outdoor department for diseases peculiar to women, 329. The number of patients treated at the dental department was 227. The number of deaths during the year has been 282—viz., 210 males and 72 females. Of these 102 died within 48 hours of their admission, and many others were admitted in a hopelessly diseased or maimed condition, for whom all the best efforts of the institution were employed to alleviate their sufferings. The number of cases treated by the district surgeons in connection with the dispensary was 7,531. Of these 457 were visited at their own homes.

THE annual report of the directors of the Prince Alfred Hospital, Sydney, shows that 2,277 patients had been admitted during the year 1889, and 202 were in the hospital at the end of December, 1888, making a total of 2,479 under treatment during the year. Of these 1,339 had been cured, 520 had been discharged relieved, 166 were unrelieved, and 287 had died, 197 remaining in the house at the end of the year. The rate of mortality over all the cases under treatment was 11.26. Many of the deaths were those of persons admitted in a hopeless condition, and many others were in the last stage of phthisis. The outdoor cases attended numbered 26,959, or 1,120 more than during the previous year. Urgent cases or accidents accounted for 761 of the patients, Government vouchers for 513, while 975 contributed more or less towards their support in the hospital. Numerous beds had been monopolised by a number of chronic cases, whose chief need was nursing. The want of accommodation of a cheaper character was referred to, as chronic and incurable cases could be satisfactorily accommodated in buildings

costing about half for their erection and support. There was urgent need for a home for phthisical patients. In dealing with average rates of mortality and length of residence in hospital of typhoid fever cases, a table was given showing how the rate of mortality increases in proportion to the length of time the patient had been ill before admission. Of those admitted in the first week the deaths were 2.15 per cent., while of those admitted in the fourth week the rate was 41.17 per cent. Medical and surgical statistics were given showing the large proportion of serious cases treated, and the excellent results obtained.

DURING the year 1889 219 patients were admitted into the Sydney Hospital for Sick Children, making a total of 259 under treatment. Of these 206 were discharged cured or relieved, 22 died, and on December 31 there were 31 remaining in the hospital. The number of operations performed was 82. The payments from parents and friends of patients had amounted to £527 18s. 5d., being considerably larger than during the previous year.

A FARMER near Wagga died from blood-poisoning a few days after skinning a beast that had died from pleuro-pneumonia; it is stated that the deceased had a cut on his hands, and it is supposed that the virus was communicated to his system by this means.

DR. R. J. ALLAN, of Ashfield, has removed to Smith Street, Summerhill.

DR. ALEX. BARBER, late of Mudgee, has commenced practice at Hillgrove, in a gold and antimony mining district 20 miles from Armidale.

DR. F. CALDER, a new arrival, has commenced practice at Lismore, in conjunction with Dr. H. E. L. Pratt.

DR. W. BROWN, of Parramatta, and Dr. F. H. Kyngdon, of North Shore, have returned to the colony from their trip to England by the P. & O. R.M.S. "Arcadia."

DR. F. G. CONNOR has removed from Coraki to Casino, on the Richmond River.

DR. ALLISTER COX, of 13 Bligh Street, Sydney, has been elected District Surgeon of the Sydney Hospital in the place of Dr. W. R. Clay, resigned.

DR. SYDNEY FIELDER, a new arrival, has commenced practice at Wollongong.

DR. ANDREW FREELAND, M.D. et Ch. M. Glas. 1864, died at Gundagai on February 18.

DR. W. F. GARRETT, late of the Bathurst Hospital, has been appointed Medical Officer of the United Friendly Societies in Parramatta, in the place of Dr. M. E. Wilkinson.

DR. R. B. HARVEY, formerly of Horsham, Ballarat and Creswick (Vic.), has settled at Drummoyne, a Suburb of Sydney.

DR. ARTHUR HENRY, late of the Prince Alfred Hospital, Sydney, has been appointed Resident Medical Officer at the Bathurst Hospital.

DR. H. W. MASON, of Tumut, has been appointed a member of the local Licensing Court.

DR. C. D. H. RYGATE has settled at Warren, in a pastoral district, 353 miles W. of Sydney.

DR. H. J. H. SCOTT, late of Cordillera, has succeeded to the practice of Dr. F. C. Stevenson at Scone, and Dr. J. M. Scott, a Melbourne graduate, has succeeded to his brother's practice at Cordillera.

NEW ZEALAND.

DR. F. S. DALDY has been appointed Resident Surgeon at the Auckland District Hospital.

DR. T. G. H. HALL has removed from Kamo to Kawa-Kawa (Bay of Islands).

DR. J. H. E. JARVIS, formerly of Ashford, Kent (Eng.), has settled at Napier.

DR. C. LOW, late of Dunedin, has commenced practice at Gore, 99 miles S.W. of Dunedin.

DR. M. H. PAYNE has returned to the Thames from his trip to Europe, after an absence of about eight months.

QUEENSLAND.

THE deaths in Rockhampton during the month of January show a decrease of 50 per cent. compared with the corresponding month of 1889.

DR. W. S. GEDDIE, of Gympie, has been appointed a Surgeon on the Medical Staff of the Queensland Defence Force.

SOUTH AUSTRALIA.

THE following gentlemen have been appointed additional examiners for the M.B. Supplementary Ordinary Examinations at the Adelaide University this month:—Physiology and Anatomy—Professor Anderson Stuart, of Sydney; Chemistry—Professor Masson, of Melbourne. Fifth year.—Medicine—Dr. Jamieson, of Melbourne; Surgery—Dr. McCormick, of Sydney; Obstetrics, &c.—Dr. W. Balls-Headley, University of Melbourne; Hygiene—Dr. Whittell; Ophthalmic and Aural Surgery—Dr. Symons and Dr. Giles.

DR. A. E. N. BROWNE, formerly of Burbage, near Marlborough (Eng.), is now practising at Gawler, 26 miles N.E. of Adelaide.

DR. E. ELPHICK has removed from Maitland to Prospect North (Adelaide).

DR. F. W. COUNTER has commenced practice at Willunga, 80 miles S. of Adelaide.

DR. MAGAREY has left for London by the steamer "Parramatta."

TASMANIA.

THE Government have appointed Dr. E. L. Crowther Honorary Consulting Surgeon, and Dr. E. J. Crouch Honorary Consulting Physician to the Hospital for Insane, Cascades, near Hobart.

VICTORIA.

At a recent meeting of the Council of the Melbourne University the following motion was lost by the casting vote of the Chancellor:—"That the Senate endeavour to obtain such alteration in the University Act, 1881, as will entitle women graduates to become members of the Senate and Council, and to share in all other academical privileges enjoyed by male graduates."

At the annual meeting of the Victorian branch of the British Medical Association held on February 12, Dr. Le Fevre was elected President, Dr. Shields, Vice-President, Dr. Meyer, Secretary, and Dr. Kenny, Treasurer.

THE number of cases of typhoid throughout the colony reported to the Central Board of Health during the week ending the 15th February was 240, of which 81 were fatal, showing a considerable increase in the rate of mortality over the previous week. There were 60 cases of diphtheria, 8 of which were fatal.

THE total number of typhoid cases in Melbourne and suburbs from December 1, 1889, to 15th February, 1890, was 1,024, and of deaths 106.

A SCHOOL near Minyip had to be closed last month as more than half the scholars were suffering from ophthalmia.

A VERY serious outbreak of diphtheria has occurred at Elsternwick, a suburb of Melbourne. Dr. Shields, the Government medical officer, reports the want of drainage to be the main cause of the outbreak.

THE board of management of the Melbourne Homoeopathic Hospital have resolved to appoint an additional resident medical officer to the institution, and to invite applications for the position from England and America besides these colonies.

DR. J. T. BRETT has returned from his trip to Europe and resumed practice at 85 Collins-street, Melbourne.

DR. M. CRIVELLI, of South Melbourne, has left for France by the M.M. steamer "Salacie."

DR. T. T. DICK, Inspector of Lunatic Asylums, in Victoria, has been appointed a member of the Police Superannuation Board.

DR. J. B. DONALDSON has removed from Yarrawonga to Linton, 126 miles west of Melbourne.

DR. H. MARTIN DOYLE, late of Port Melbourne, has left for England by the s.s. "Sobraon."

DR. A. W. ESLEB, late of Belfast (Ireland), has commenced practice at Heathcote, in a gold-mining district, 70 miles north of Melbourne.

DR. J. W. FISHBOURNE, of Moonee Ponds, has been appointed Examiner at the Melbourne University for the degree of M.D. in the subjects of Mental Pathology, Mental Therapeutics, and Mental Hygiene.

DR. H. T. FOX has removed from Beechworth to Bairnsdale, where he has commenced practice in conjunction with his son, Dr. J. R. Fox, a graduate of the Melbourne University.

DR. N. B. GANDEVIA, a recent arrival, has settled at Brankholme, 240 miles west of Melbourne.

DR. E. J. GLEESON, of Fitzroy, has left for England by the R.M.S. "Oceana."

DR. C. WERNER GUNST has commenced practice at 127 Collins-street, Melbourne.

DR. EUSTACE J. KEOGH has commenced practice at 173 Toorak-road, South Yarra.

DR. E. ALLAN MACKAY, late Junior House Surgeon at the Adelaide Hospital, has been appointed Resident Surgeon at the Children's Hospital, Melbourne.

DR. E. J. MINCHIN, late Resident Surgeon of the Melbourne Women's Hospital, has commenced practice at Williamstown.

DR. G. G. O. PHILLIPS, late of Warwick (Qd.), has succeeded to the practice of Dr. Bean at Heidelberg, near Melbourne.

THE Committee of the Melbourne Women's Hospital have presented a testimonial to Dr. Lionel F. Praeger, of East Melbourne, for his services as assistant resident medical officer and acting senior resident medical officer from February to June last year.

DR. SKELENMEYER, of Collins-street, has been re-appointed Honorary Surgeon of the Melbourne Homoeopathic Hospital.

DR. F. A. SWEETNAM, late of Air-hill, Schull (Co. Cork, Ireland), has settled at Peshurst, in an agricultural and pastoral district, 181 miles west of Melbourne.

DR. F. A. WATKINS, late of Newport, Monmouthshire (Eng.), has settled at Smythesdale, the centre of a large mining district, 115 miles W. of Melbourne.

WESTERN AUSTRALIA.

DR. CHARLES LOVEGROVE has been appointed Resident Medical Officer at Carnarvon, vice Dr. F. J. Roberts, resigned.

PROCEEDINGS OF THE COLONIAL MEDICAL BOARDS.

The following gentlemen, having presented their diplomas, have been duly registered as legally qualified Medical Practitioners by the respective Boards:—

NEW SOUTH WALES.

Calder, Frank, L.R.C.P. Lond. 1888; M.R.C.S. Eng. 1888.
Kane, Francis William, L.R.C.P. Edin. 1889; L.F.P.S. Glas. 1889; L.R.C.S. Edin. 1889.
Pilkington, Francis Berget, L.R.C.P. Lond. 1880; M.R.C.S. 1879.
Poland, James Harry, L.S.A. Lond. 1877; Dip. Pub. Health R.C.S. Irel. 1889; Dip. State Med. K.Q.C.P. Irel. 1889; M.R.C.S. Eng. 1877.
Bartley, Joseph Francis, M.B. Univ. Melb. 1888; Ch. B. Univ. Melb. 1888.
Williams, Frederick, M.R.C.S. Eng. 1841; L.S.A. Lond. 1840.
O'Brien, Philip Kennedy, M.R.C.S. Eng. 1888; L.R.C.P. Lond. 1888.
Felder, Sydney, L.K.Q.C.P. Irel. 1889; L.S.A. Lond. 1889.
Scott, John Melby, M.B. Univ. Melb. 1889.

NEW ZEALAND.

Jarvis, Joseph Henry Ernest, M.R.C.S. Eng.; L.R.C.P. Lond. 1887.

QUEENSLAND.

Hoggan, Bertram Brooks.
Shiels, Edward Estelle, L.R.C.P. & R.C.S. Edin. 1883.
Thompson, Robert, M.B. & Ch.B. Durh. 1888; M.R.C.S. Eng.; L.R.C.P. Lond. 1888.
Somers, James Louis Edgeworth, L.R.C.S. Irel. 1883; L.A.H. Dubl. 1883.
Webb, Malcolm, M.D. Lond. 1884; M.R.C.S. Eng. 1882.

TASMANIA.

Drake, Francis John, M.B. & Ch.B. Melb. 1888.

VICTORIA.

Watkins, Frank Augustus, M.R.C.S. Eng. 1887; L.R.C.P. Lond. 1887; L.S.A. Lond. 1887.
Cranstone, William Lefèvre, M.R.C.S. Eng. 1881; L.S.A. Lond. 1881.
Sweetnam, Frank Arthur, L. & L. Mid. R.C.P. & R.C.S. Edin. 1887; L.F.P.S. Glas. 1889.
McInerny, John, L.S.A. Lond. 1889; M.D. C.P.S. City of New York.
Ewing, Samuel Arthur, L. & L. Mid. R.C.P. & R.C.S. Edin. 1889; L.F.P.S. Glas. 1889.
Boughton, William Blockley, L. & L. Mid. R.C.S. Edin. 1877; L.S.A. Lond. 1878.
Gandevia, Navroji Bamanji, M.R.C.S. Eng. 1883; L.R.C.P. Lond. 1883.
Stone, Emma Constance, L.S.A. Lond. 1889; M.D. & Ch.M. Univ. of Trinity College, Toronto.
Euler, Alfred William, M.D. Ch.M. & M.A.O.R. Univ. Irel. 1887.
Leslie, Louis Gordon, L. & L. Mid. R.C.P. & R.C.S. Edin. 1873.
Potts, Walter Alfred Beevor, L.S.A. Lond. 1883; M.R.C.S. Eng. 1886.

Additional qualifications registered:—

Saunders, John H., Ch.B. Melb. 1889.

WESTERN AUSTRALIA.

O'Connor, Michael, M.B. Ch.B., B.A.O. Univ. Dubl. 1889; L. Mid. Bot. Lying-in Hosp. Dubl. 1889.

MEDICAL APPOINTMENTS.

Brockway, Archibald Birt, L.R.C.P. Lond., M.R.C.S.E., to be Government Medical Officer at Muttahwa Qu.
Branson, George Attenborough, M.R.C.S.E., L.R.C.P. Ed., to be Health Officer for Shire of Yarrowonga, Vic.
Counter, Francis William, M.B. & Ch.M., to be a Public Vaccinator for Willunga, S.A.
Gaffney, Charles Burke, F.R.C.S. Irel., L.K.Q.C.P. Irel., to be Health Officer for Shire of Strathfeldsay, Vic., vice Dr. E. Hincholiff.
Gandevia, Navroji Bamanji, M.R.C.S.E., L.R.C.P. Lond., to be Public Vaccinator at Brankholme, Vic., vice Dr. J. F. Matthews, resigned.
Hall, Thomas Gibson Henry, L.R.C.S. Irel., L.K.Q.C.P. Irel., to be Public Vaccinator for the District of Kawakawa, N.Z.
Hamilton, Charles Wolfe, M.B. & Ch.B. Dubl., to be Officer of Health for Laura, S.A.
Hayes, Horace Frederick, M.B. & Ch.M. Melb., M.R.C.S. Eng., to be Health Officer for Shire of Bulla, Vic.
Low, Charles, M.B. & Ch.M. Edin., to be an additional Public Vaccinator for the District of Gore, N.Z.
McNaughton, John, M.B. & Ch.M. Edin., to be Health Officer for Shire of Dunmunkle, N.R., Vic., vice Dr. Broom.
O'Sullivan, Edward Francis, M.D. & Ch.M. Roy. Univ. Irel., to be Public Vaccinator at Yarrowonga, Vic., vice Dr. J. B. Donaldson, resigned.
Renner, Frederick Emil, M.D., to be Health Officer for Petersburg, S.A.
Somers, James Louis Edgeworth, L.R.C.S.I., to be Government Medical Officer at Ayr, Qu., vice Dr. W. M. King, resigned.
Watkins, Frank Augustus, L.R.C.P. Lond., M.R.C.S.E., to be Public Vaccinator at Smythesdale, Vic.
Wright, Francis G., L.R.C.P. & R.C.S. Edin., to be a Public Vaccinator in South Australia.

BIRTHS, MARRIAGES, AND DEATHS.

* * The charge for inserting announcements of Births, Marriages, and Deaths is 2s. 6d., which should be forwarded in stamps with the announcement.

BIRTHS.

BOWMAN.—February 8th, at Parramatta, N.S.W., the wife of Reginald Bowman, M.B., &c., of a daughter.
CONNOR.—On the 4th February, at Casino, N.S.W., the wife of Dr. F. G. Connor, of a son.
ERSON.—On January 30, the wife of Dr. W. R. Erson, of Onehunga (Auckland), of a daughter.
FAULKNER.—January 23rd, at Hastings, Hawke's Bay, N.Z., the wife of Joseph Faulkner, M.R.C.S.E., L.R.C.P.L., of a son, stillborn.
INGLIS.—On the 3rd March, at Kew, Melbourne, the wife of E. M. Inglis, M.B., of a son.
M'KILLOP.—February 6, at Goulburn, N.S.W., the wife of Robert M'Killop, F.R.C.S.E., of a son.
MILES.—On the 28th February, at Callan Park, near Sydney, the wife of George E. Miles, L.R.C.P., of a daughter.
PARKINSON.—On the 10th February, at Malvern, Melbourne, the wife of Dr. C. J. Parkinson, of a son.
PINNOCK.—On the 14th February, at Ballarat, Vic., the wife of Robert Denham Pinnock, M.D., Surgeon-Major Victorian Military Forces, of a daughter.
SEELENMEYER.—On the 15th February, at Collins-street, Melbourne, the wife of A. F. Seelenmeyer, M.D., of a son.
SMEAL.—On the 13th February, at Ararat, Vic., the wife of Dr. James Smeal, of a son.
STEWART.—On the 23rd February, at Hindmarsh, S.A., the wife of Dr. R. Stewart, of a son.
WEEKES.—February 12, at Lithgow, N.S.W., the wife of Charles J. Weekes, M.R.C.S. Eng., L.R.C.P. Lond., of a daughter.

MARRIAGES.

BAIRD-MOIR.—On the 29th January, at Geelong, Vic., by the Rev. C. J. Baird, John Chalmers Baird, M.B., B.S., Healesville, to Annie Stephen, daughter of the late Rev. J. S. Moir, Sandhurst.
FISHER-THOMPSON.—On the 31st March, at Wollongong, by the Rev. T. C. Ewing, R.D., Thomas Carson Fisher, M.D., of Bowral, N.S.W., to Elizabeth, third daughter of the late Andrew Thompson, of Horsley, Illawarra.

DEATHS.

ADAM.—On the 27th February, at East Melbourne, Linda Eveline Grace, the daughter of Dr. G. Rothwell Adam, aged 16 months.
FAULKNER.—January 28th, at Hastings, Hawke's Bay, N.Z., Fanny Antoinette Giesen de Morny, wife of Joseph Faulkner, M.R.C.S.E., L.R.C.P.L., in her 35th year.
VON LOSSBERG.—On the 13th February, at her parents' residence, Ipswich, Qu., Christiana Wilhelmine Emma, daughter of W. Henry Von Lossberg, M.D.

REPORTED MORTALITY FOR THE MONTH OF JANUARY, 1890.

[illegible]

METEOROLOGICAL OBSERVATIONS FOR JANUARY, 1890.

[illegible]

AUSTRALASIAN MEDICAL GAZETTE.

ORIGINAL ARTICLES.

A CONTRIBUTION TO THE HISTORY OF MEDICINE IN AUSTRALIA.

By A. MUELLER, M.D., YACKANDANDA, VICTORIA.

WHEN, three years ago, I reported officially to the Central Board of Health of Victoria, as Health Officer to the local Board, that I had solved the problem of snake-poisoning in Australia, I was politely informed by the Chief Medical Officer, to whom the subject had apparently been relegated, that I would have to demonstrate the efficacy of my antidote on lower animals, and also bring the matter before the Medical Society of Victoria. Notwithstanding the fact that I had practised my method for years on the highest animal, man—that its unfailing efficacy has been proven by other medical men during the last two years in numerous most telling cases, and that in consequence deaths from snake-bite are almost events of the past now in Australia—the guardians of public health have honoured me with no official recognition of my labours.

My report to the Central Board was no sooner made public than *The Argus* in Melbourne opened its columns to a well-known medical man who, though not shining as a practitioner, dabbles in general literature, and is supposed to be a learned expert in snake lore. Under the ægis of the editorial “we” this individual attempted most furiously to write me down, charging the would-be discoverer with ignorance of the labours (i.e., failures) of his predecessors in this field of research, and citing a few unfavourable experiments with strychnine on dogs as an all-sufficient refutation of the correctness of my theory and treatment. It was in vain that I remonstrated and showed the utter futility of his arguments. My replies to him were even refused admission, and it was only after I brought some private influence to bear that a short letter found its way into the columns of the paper, but only to be commented on most unfairly in another sub-leader. Undaunted, however, by these rebuffs, I proposed to bring the subject before the Victorian Medical Society, and after some preliminary difficulties was graciously accorded permission to read a paper at a meeting in May, 1887. Fully prepared for a formidable array of scientific objections I was, alas, again doomed to disappointment, for not a single one was advanced or opinion offered either for or against my theory. I was only confronted again with arguments, chiefly reiterated from *The Argus*, that did not even

touch my position, far less shake it in the slightest degree.

Had I allowed myself to be discouraged by this almost hostile reception, and had there not been men of independent judgment like Dr. Thwaites, of Tallangatta, who adopted my method of treating snake-bite, it would by this time have fallen into oblivion, and most undoubtedly many valuable lives would have been lost. But by far the greatest help I have received has been from *The Australasian Medical Gazette*. The readiness with which its columns were opened to me, and the generous support accorded to me by its able editor, have been very considerable factors in the success that has crowned my efforts, and stand in marked contrast to the attempts made in Melbourne to thwart them.

That in the face of this success, in the face of the fact that no medical man in Australia now can dare to treat a case of snake bite by any other than my method, without incurring the charge of culpable ignorance or neglect in case of the patient's death—that in the face of all this, the paper I read before the late Australasian Medical Congress at Melbourne has been apparently deliberately suppressed and left out of the published transactions, is a crowning act of iniquity for which those who perpetrated it richly deserve the pillory, on which I now place them by submitting the subjoined correspondence for publication :

Yackandandah,

9th February, 1890.

SIR,—I have the honor to call your attention to the fact that the important paper I read before the Section for Pharmacology at the late Intercolonial Medical Congress, on the use of strychnine in snake-bite (*at the special request of the Secretary, Prof. Allen*), has not appeared in the published transactions, and to request that you will have the goodness to inform me why it was omitted, since both its contents and its shortness appear to preclude the only excuse that might be advanced for this omission. In support of this request I must inform you that when Dr. Thwaites had given notice of his intention to lay the notes of his two very successful cases—treated by my method—before the Congress, Professor Allan wrote to me that it would be desirable for me to read a short paper on my theory of the action of snake poison and the treatment proposed by me *previous* to Dr. Thwaites reading his notes. With this request I complied, but find to my utter amazement that only Dr. Thwaites' notes have been published, and in the place of my paper the mere sentence, “*After the reading of the foregoing notes Dr. A. Mueller added a few remarks.*” This, you will perceive, is positively untrue, and the Secretary for the Section must have known it to be so when he allowed it to go to the printers. My paper was read *before* Dr. Thwaites' notes, and in elucidation of those notes, and it contained in a concise form all that was necessary for that purpose. In the discussion that followed, and in which Dr. Kirtikar of the Indian Army Medical

Staff took a prominent place, no unfavourable comments were advanced, and you may therefore be assured that, from a scientific point of view, the paper was unobjectionable.

I must further inform you that I received from Professor Allen subsequently, in conversation, the assurance that the paper which he had evidently read, and which he called a "splendid" one, would most certainly appear in the transactions. The action of the Literary Committee with regard to it, therefore, places that gentleman in a very anomalous position. But it would be an insult to him, and totally at variance with his high reputation, both as a scientist and a gentleman, to suppose for a moment that he connived at the suppression of the paper. Similar reasons preclude the possibility of your having sanctioned it, prevented, moreover, as you must have been by your large practice, from attending to minutiae of this kind in fulfilling the duties devolving on you as President of the Congress and member of the Literary Committee. I therefore respectfully request that you will have the goodness to elicit from the Secretary of the Section for Pharmacology and those members of the Literary Committee who were entrusted with the papers for that section, what reason they can give for the rejection of a paper dealing with an important original and now fully established Australian discovery.

Within the last twelve months numerous cases of snake-bite in all parts of Australia have successfully and without a single failure been treated by my method, some of them, like that of Mr. R. Johnstone, P.M., of Maryborough, Queensland, at the very point of death. The rapid adoption of this method, however, is entirely due to my own unceasing efforts, and not to any assistance from those whom I might have expected it and to whom I appealed for it in the first instance. The Medical Society of Victoria, after finding that snubbing and open opposition were unavailing, has now adopted towards me a policy that may be designated as "the conspiracy of silence." Looking at the names of at least some of the gentlemen composing the Literary Committee, you will probably share my conviction—that it is to this policy I owe the rejection of my paper.

I have the honor to be, Sir,

Your most obedient servant,

A. MUELLER, M.D.,

T. N. FITZGERALD, Esq., F.R.C.S.I.,
President Second Session of Intercolonial Medical Congress, Melbourne.

Lonsdale-street West, Melbourne,

13th February, 1890.

DEAR DR. MUELLER,—Your letter with reference to the non-publication of your paper on snake-bite in the Congress transactions duly to hand.

As you know, Professor Allen has gone to Europe, and Dr. Grant, the Secretary of the Pharmacological Section, is just at present on a holiday in Tasmania. Immediately upon his return I will make enquiries and let you know the result.

Although a member of the Literary Committee, I had nothing to do with the publication of the papers in that section.

I very much regret that your paper was omitted, as we were all most desirous of publishing original papers on Australian subjects.

With kind regards,

Believe me,

Very truly yours,

T. N. FITZGERALD.

DR. MUELLER,

Yackandandah.

16 Collins-street East, Melbourne,

22nd February, 1890.

DEAR SIR,—In answer to your inquiry as to the non-publication of Dr. Mueller's remarks on "snake-bite" in the transactions of the Intercolonial Medical Congress, I beg to say that the remarks in question were identical in substance with a paper recently read at the Medical Society of Victoria and published in the *Australian Medical Journal* by Dr. Mueller. It was laid down as a definite principle regulating the action of the Literary Committee that no matter previously published should be included in the transactions, and on this ground the remarks read by Dr. Mueller were not eligible for publication. I may add further, that Dr. Mueller's contribution was simply a part of the "discussion" on the notes of two cases of snake-bite read by Dr. Thwaites, and that the limitation of space prevented the inclusion of such remarks. Dr. Kirtikar, for example, made a somewhat lengthy and very interesting speech on the same subject, which was not reported in the transactions. But the chief reason for the omission of Dr. Mueller's remarks was the fact of their prior publication.

I am, yours faithfully,

D. GRANT.

T. N. FITZGERALD, Esq.

Yackandandah,

28th February, 1890.

DEAR SIR,—In returning to you herewith Dr. Grant's letter kindly sent to me for perusal, it is scarcely necessary for me to point out that the two reasons given by Dr. Grant for the non-publication of my paper on snake-bite in the transactions of the Intercolonial Medical Congress—the first one is based on a misrepresentation, the second one on an absolute falsehood.

The paper I read before the Congress, though dealing with a subject I had already laid before the Medical Society in May, 1887, *was not identical in substance* with that read before the Medical Society and published in the *Australian Medical Journal*. The inductive and deductive proofs of the correctness of my theory of the action of snake poison were more clearly and distinctly laid down in the Congress paper, and the letter, moreover, contained records of experiments as to the action of snake poison on the blood, not previously published by me. If, therefore, the mere fact of the subject of my paper having been dealt with in previous publications rendered it not eligible for publication, as Dr. Grant asserts, it is very evident, that if the same rule had been applied to all other papers, the transactions of the Congress would have been reduced into a very small compass, for very few papers would have stood that test. With regard to the second reason given by Dr. Grant I regret the necessity of having to charge that gentleman with a deliberate falsehood. My paper was not, as he alleges, part of the discussion on the notes of two cases of snake-bite read by Dr. Thwaites, but on the contrary, the discussion was on my paper. The President of the Pharmacological Section, Baron v. Mueller, called on me in the first instance to read my paper, and after I had done so, on Dr. Thwaites to read the notes of his two cases in illustration of it. Then followed the discussion, in which Drs. Dixon, Kirtikar and myself took the principal part. I do not complain of the non-publication of the discussion, but you will doubtless agree with me that I have strong reason to complain of the deliberate omission of my paper, since it dealt with an important and original Australian discovery, and was read at the special request of the Secretary, Professor Allen.

Moreover, anticipating that the Literary Committee would probably comprise among its members a few of my "friends" of the Medical Society, I obtained from Professor Allan a distinct verbal promise that the paper should be published in the transactions of the Congress.

As it is therefore evident that the Literary Subcommittee entrusted with the papers read before the Section for Pharmacology were influenced in their action with regard to my paper by other reasons than those alleged by Dr. Grant, and as this action, now irrevocable, is not the result of an oversight, which I would have forgiven, my only redress lies in the publication of this correspondence.

I am, Dear Sir,
Yours obediently,
A. MUELLER.

T. N. FITZGERALD, Esq., F.R.C.S.I.,
Melbourne.

The following is the paper referred to in the foregoing correspondence:—

"The use of strychnine in snake-bite is not the result of an empirical search for an antidote, but the logical outcome of a theory, the correctness of which can be demonstrated by the inductive as well as the deductive method of scientific investigation. It is therefore necessary for me to give a short explanation of the theory, though it belongs more properly to the domain of pathology. Simply and briefly stated it contends that snake poison is not a blood, but a specific nerve poison; that it lowers the functional activity of the motor nerve centres, and thereby reduces the volume and force of motor nerve currents throughout the body, interfering with the normal force transmission from cell to cell as well as from cell to peripheral fibre. If you pass in review the symptoms accompanying the poisoning process, you will find that they can all be explained by this theory. In recent contributions to *The Australasian Medical Gazette* I have given these inductive proofs, and I am now here to supply, to the best of my ability, any deficiency that may be pointed out, and give any explanation that may be required.

"The most difficult part of the task to prove the theory inductively was that of accounting for the peculiar and characteristic condition of the blood after death from snake-bite.

"It was necessary in the first instance to demonstrate by experiment that this condition is not the result of either chemical or antiplastic action of the poison. For this purpose I treated the warm arterial blood of a hen in a test tube with poison obtained from the glands of a tiger snake by immersing the well-filled and corked tube into water of blood heat, and shaking it frequently. Another hen was then killed by an injection of a few minims of the diluted poison from the same snake, and a test tubeful of its blood collected from the left ventricle and aorta. Comparison showed a marked difference between the two samples of blood. That which had been treated in the tube with poison had not changed its bright red colour, and under the microscope showed all corpuscles perfectly normal and intact. The blood taken from the poisoned hen was unusually dark in colour, much more liquid than the first, and microscopically, besides normal corpuscles, presented numerous broken up ones in form of the usual granular masses. In a third experiment, having for its object to show that snake poison is not destructive to protoplasm, or antiplastic in its action, I crushed the glands from a

black snake with a test tubeful of water swarming with infusoria, and in another tube reserved some of the same water for comparison with that saturated with the snake poison and likewise set aside in a test tube. Comparing the two from day to day under the microscope I found that the snake poison rather stimulated than destroyed infusorial life, and that under its influence fresh species made their appearance, which I could not detect in the water free from it.

"The results of these experiments greatly strengthens my contention that the action of the snake poison is purely dynamic force—but not tissue-destroying, that it merely suspends the action of the nerve cells without interfering with their structure. Unfortunately, our present state of physiological knowledge makes it impossible for me to account for the blood changes in snake poisoning on this theory without having recourse to a hypothesis, which, however, is supported by some collateral facts. It refers to the agreement between the diameter of the blood corpuscles and the lumen of the finest pulmonary capillaries, through which the oxygen is absorbed and the carbonic acid given out. Both these gasses are carried from and to the lungs by these living cells, in all probability amoebæ, which, in order to effect this life-sustaining exchange must come into intimate contact with the capillary tube and pass through it in single file. Now this tube owes the tension, the healthy tonic contraction, necessary for this intimate contact with the corpuscles to vaso-motor nerve influence, and must expand in proportion to this nerve influence being weakened. Blood-serum, in consequence, will press in between the corpuscles and tube, and prevent the proper exchange of gases. The blood cells re-enter the arterial circulation with an insufficient supply of oxygen, and only partially liberated from the carbonic acid they carried to the lungs. Absorbing fresh quantities of it in their course through the system they return to the lungs, to leave them with the same if not a worse result. Thus the blood becomes overcharged with carboic acid, and many of the corpuscles die, literally bursting in consequence of this overcharge.

"Turning from the inductive proofs of the correctness of my theory to the deductive ones, drawing from it certain conclusions to which, if correct, it must necessarily lead, all the arguments in its favour gain immensely in force. Reasoning then from the theory by assuming its correctness, the first test of it that suggests itself is to use as an antidote a remedy that stimulates the depressed functional activity of the motor nerve centres under the influence of the snake poison. If such stimulation removes the distressing symptoms, it triumphantly proves the correctness of the theory.

"It is now 10 years ago that I first applied the force of this reasoning to an all but hopeless case of snake-bite by hypodermic injections of liq. strychnia. My patient was in a state of extreme collapse, comatose, with shallow respiration and all but imperceptible pulse at the wrists. You may imagine with what anxiety I watched the effect of the antidote; with what exuberance of joy I saw the coma change into sleep, the sleep into perfect consciousness, and after the second injection all the distressing symptoms disappear. There is much in the practice of our noble profession that is purely empirical. We daily prescribe certain remedies for certain morbid conditions, simply because experience has taught us that certain beneficial effects will follow; but the exact nature of the disease we treat, and the exact *modus operandi* of the remedy we administer, are frequently anything but clear to us, and sometimes, I fear, our conclusions as to the *post hoc propter hoc* of the results we obtain are

erroneous. With regard to snake-bite, we were hitherto in the unfortunate position of knowing neither disease nor remedy; successful in ordinary cases in which the poison had been checked by ligature and excision, but perfectly helpless in severe ones of unchecked absorption. I am both proud and happy to assure you with the most perfect confidence that our position in this respect is now exactly reversed, and I shall not cease in my efforts until the universal verdict of the medical profession confirms this statement, and strychnine is established in medical practice as the recognized antidote for snake poison. I have never yet used it as such without immediate and surprising beneficial effect, but the number of really valuable well-pronounced cases of snake-bite in one man's practice is necessarily small; and as I have already published the best ones of those I treated with the antidote I will not now refer to them, more especially since testimony altogether independent of mine is about to be laid before you. Dr. Thwaites, of Tallangatta, the first medical practitioner who, in the face of much hostile criticism and condemnation of the antidote, showed the courage of his opinion by using it in two very serious cases of tiger snake-bite, will give you his notes of these cases. You will find both typical and well pronounced. His last, one of a girl of 13 years, in whom pulse at the wrists and even perceptible respiration had already ceased, and a faint fluttering of the heart was the only lingering sign of life, is simply unique, and should carry conviction to your minds if my remarks have failed to do so. This case, moreover, is attested by another graduate of this University, Dr. Flanagan, who witnessed it. All I ask of those of you who have the opportunity is a fair trial of the antidote in actual practice, and a fair record of the results. Do but this, and we will all see the day on which deaths from snake-bite under medical treatment will be events of the past."

[We are of opinion that Dr. Mueller is fully justified in the indignation which he expresses at what we think he fairly terms the *suppression* of his paper in the publication of the proceedings of the Section of Pharmacology of the last Australasian Medical Congress. The subject is one of especial interest, not only to the medical profession but to the people generally, and when reporting successful cases of its use to omit all mention of the medical man at whose suggestion and on the evidence of whose researches the antidote had been used in such cases, can only be characterized as contemptible conduct on the part of the person by whose mal-influence it was left out. No adequate reparation to Dr. Mueller is now possible, for his valuable paper having been omitted from the officially published report of the second Congress, there will remain no public record of the highly scientific course of induction by which he was led to so courageously adopt this antidote for snake-poison, now proved to be successful, except such as we are gladly able to afford him in the columns of this journal. To do him bare justice it will be necessary to bring the subject before the next session of the Congress, when a resolution expressive of condemnation by that body of the conduct of the person or persons actually responsible for this mean action must in all fairness be passed and placed prominently on its records for future reference. The paltry excuse given by Dr. Grant for the non-publication of Dr. Mueller's paper, even if true, which we dispute, is one which, in a discovery of such importance, should not have been acted upon. To quote publication in such a merely local paper as the medical journal in Melbourne—which is hardly known beyond the narrow circle of the

members of the Medical Society of Victoria—as equivalent to publication in the transactions of the Congress is ludicrously absurd, and the mind of the man who could advance this as a reason for the exclusion of the paper from such publication must be a curious psychological study, with which, however, we would desire to avoid any very close contact.—ED. A.M.G.]

CASE OF SNAKEBITE.

By E. ST. GEORGE QUEERLY, LATE GOVERNMENT MEDICAL OFFICER, MAYTOWN DISTRICT, QUEENSLAND.

LAST month, for the first time, I used Dr. A. Mueller's antidote in a case of snakebite, and must say that it acted in a most satisfactory manner. I think the case worthy of notice, as in the first place the snake was very poisonous, and secondly because the injection of the liq. strychniæ was the sole treatment, 65 minims in all being used, and finally because the third injection dispelled all sleep symptoms and depression under which the patient was labouring.

J. P., æt. 19, whilst working in a paddock was bitten on the left leg three inches above ankle, by a black snake having a red belly. He immediately scarified wound and tied a handkerchief above bite and rode into town, a distance of sixteen miles. When I saw him, about two hours after occurrence, I found him in a state of collapse, cold extremities, pinched expression of face, and great inclination to sleep. I immediately had handkerchief removed and injected 15 minims of liq. strychniæ, and twenty minutes afterwards injected a similar amount, both in neighbourhood of bite.

Shortly after, patient vomited a large quantity of bile-stained fluid. He now for the first time had a little brandy and water, but only kept it down for a short time. The drowsiness became great, in fact patient going to sleep in any position, so I injected 20 minims of the liq. into his left arm. This last injection seemed to have a marked effect, as all inclination for sleep gradually passed away, and patient expressed a wish to walk about, and said he felt much better.

One hour after this I again injected 15 m. of liq. strychniæ, and now noticed some muscular spasms. I kept him under observation all the evening, and in the morning he was well enough to ride home.

Two days afterwards his mother called and told me that he suffered a great deal of pain for two nights in his joints, the worst being situated in his groins; however, the next day the lad called to say he was all right, except that he had completely lost his sense of taste.

NOTES OF THREE CASES OF SNAKE-BITE TREATED BY SUBCUTANEOUS INJECTIONS OF STRYCHNINE.

By H. C. GARDE, F.R.C.S., SURGEON TO THE MARYBOROUGH HOSPITAL, QUEENSLAND.

CASE 1.—At about 7 a.m. on Jan. 26th, Miss H—, aged 13 years, was bitten on the outer side of right ankle by a large brown snake. Within a minute or two a small sized rope was wound around the leg from the ankle to above the calf, and she started on horseback for town, having to come six miles, and being delayed in crossing the River Mary in flood state, she did not arrive at hospital until 9 a.m. She was then in a nervous and exhausted condition, and had some dragging of the lower limbs on trying to walk. The two punctures were plainly visible. Free incisions were made across them, and the foot placed in warm water; the parts being congested bled freely, pressure converging towards the wound was made to increase the flow. Next \mathfrak{m} xv. of the Liq. Strychniæ, P.B., were injected into the subcutaneous tissues of the thigh, and five minutes afterwards the ligature was removed. As she looked like fainting, an ounce of whisky in a little cold water was given. Ten minutes later ten more drops of Liq. Strychniæ were injected, and by 1 p.m. she felt well enough to return home.

Case 2.—On Jan. 28th, a Kanaka, aged about 22 years, was brought in from Jindah Plantation. He was bitten by a snake just above the ankle, and a ligature was applied at once just above the punctures and another one about three inches further up the leg. He was unable to tell what kind of snake had bitten him, not being able to speak English. With the exception of his not getting any whisky, similar treatment was adopted, and he got all right in a couple of hours.

Case 3.—On Feb. 26th, W. O—, aged 16 years, was bitten by a whip snake on the ankle. He at once tied his belt tightly around the leg above the wound. He was brought into town about an hour afterwards. The symptoms were slight, indeed might fairly be ascribed to fright, only one injection of \mathfrak{m} xii. Liq. Strychniæ was used. Wound treated same as other two cases.

Remarks: In all of the cases the bites were situated in nearly the same position, and as none of the patients had on boots or socks, the fangs were applied to the skin direct. The brown snake is looked upon by good authorities as being the most poisonous of all the Queensland snakes. Mr. Johnstone, P.M. of this town, who has lived

for over twenty years in the northern parts of this Colony and who has had considerable experience of snakes, tells me that he saw twelve people who had been bitten by brown snakes, and, as he expressed it, he “attended the funerals of the lot,” while of seven cases of bites by deaf adder four are alive at present. He had the misfortune to have been bitten himself some six months ago by a brown snake, and was treated by Dr. Bowe, of Gympie, at first with injection of Liq. Ammoniacæ, and afterwards with Liq. Strychniæ, to the latter of which he ascribes his recovery. I may say that his case was worse than any of the three treated by me, as he got quite insensible and had in addition to have artificial respiration carried on for a considerable time. He informs me that the whip snake is not poisonous, at any rate Case 3 did not exhibit any symptoms that would not be accounted for by fright, so that he probably would have recovered whether or no.

THE TRUE VALUE OF QUININE IN CONTINUED FEVERS.

READ BEFORE THE MEDICAL SOCIETY OF QUEENSLAND, ON FEBRUARY 11, 1890.

By F. W. E. HARE, M.B., RESIDENT MEDICAL OFFICER, BRISBANE HOSPITAL.

THERE is probably no drug that has been so extensively prescribed in conditions of fever as quinine, and yet until very recently I have been quite at a loss to understand the true indication for its administration. This does not of course refer to its use in malaria, where its action is that of a specific, nor to its use in large doses (80 to 40 grs. and upwards) as an antipyretic in continued fevers, after the manner of Liebermeister and other German authorities. But it applies to the widely spread practice of prescribing the drug as a matter of routine, in small doses (1, 2, or 3 grs.) several times daily in typhoid and other pyrexial conditions. So administered, it has been proved to have little or no antipyretic action, and on this account the practice has been strongly condemned, more especially by those who are constantly declaiming against empiricism in medicine.

In spite of this it continues to be prescribed, and therefore it seems to me more rational to admit its benefit provisionally, and then proceed to inquire into its mode of action, than to condemn it as altogether useless because it is not easy at first sight to understand its *rationalis*.

I shall endeavour to show that in febrile diseases quinine has a powerful influence in sustaining the force of the circulation, sufficient to almost entirely obviate the tendency to cardiac failure which is so

common a feature in these affections, and one usually so unmanageable.

The simplest and most effectual way of demonstrating this will be to relate the steps that led to the observation in my own case.

Soon after the introduction of the bath treatment of typhoid it became evident that there were certain cases in which a bath of ordinary temperature and duration was quite inadequate to reduce the body heat to more than a trifling extent. Here the choice lay between two expedients: (1) to reduce the temperature of the bath water and prolong the immersion to the extent necessary to overcome the obstinacy of the pyrexia; (2) to supplement the action of the bath by an antipyretic drug. The first was very frequently employed, and I must state that I have never seen in it the slightest harm, but generally it was most distasteful to the patient, and consequently the second method was on occasion resorted to. Quinine being the antipyretic then in general use it was given in doses of 30 or 40 grains, usually on alternate evenings, after the manner of Liebermeister.

Now it has always been the rule in every case that was bathed to record on the chart, in addition to the temperatures, the pulse rate before and after each immersion. These two were observed in ordinary cases to bear a fairly constant relation to each other, that is to say, the reduction in the frequency of the pulse was roughly proportionate to the fall in temperature. Similarly, the subsequent rise in temperature was accompanied by a corresponding rise in the pulse rate, so that by the time the former had attained its previous height the latter was usually as frequent as before.

In the cases where quinine had been given the reduction in pulse rate was maintained for from 12 to 24 hours, in accordance with the prolonged antipyresis induced by the drug.

It was not, however, for some considerable time that another observation was added, and this was that although the pulse rate rose with the returning temperature it usually failed to attain its previous frequency, even when the latter had mounted to a higher level.

Full confirmation of this fact was obtained on revising the charts of former cases, where it was found that the administration of quinine had almost invariably been followed by diminished range in the pulse rate of considerably longer duration than could be accounted for by the antipyretic effect of the drug.

In addition to the reduction in rate a decided alteration in character was now observed; a pulse which had been small, soft, and *inclined to run* becoming fuller, more forcible and *distinct*. And all these signs of an improved circulation were

more marked when the quinine had been repeated.

All this, of necessity, led to an entire change of front with regard to the indications for administering the drug. From being used purely as a supplementary antipyretic it began to be prescribed, more especially in those cases in which an increasing frequency in the pulse rate gave warning of the approach of cardiac failure. Its use, however, in such large doses had certain disadvantages, chief among which was the vomiting that so frequently followed and the occasional production of a collapse. Besides which since the antipyretic effect had now become but a secondary consideration (antipyrin and antifebrin had come into general use) it naturally suggested itself that the action on the circulation might be obtained by giving small doses at frequent intervals. This was accordingly put to the test and found to fully answer the expectations that had been formed concerning it.

No useful purpose, however, would be served by quoting illustrative cases. The evidence of its action rests upon the number of instances in which it has been successfully employed as a cardiac stimulant, and especially on the fact that in hardly one has it failed. In those few where ultimate failure has resulted there has always been some special cause of exhaustion, superadded to the sources of the ordinary cardiac feebleness of pyrexia. Thus we could no more expect to support the heart's action perpetually against the constant drain caused by prolonged and uncontrollable dysentery than we could to defer indefinitely the fatal issue in a case of spinal caries with profuse suppuration.

The exhaustion in such cases is, indeed, more akin to what is seen in starvation than to that which accompanies the ordinary failure of the circulation of fever. In the former, death is intimately connected with the intestinal ulceration and is always preceded by great emaciation; in the latter it is presumably the result of the pyrexial process, for it is the usual termination in fatal cases of typhus, &c., and frequently occurs while the nutrition of the body is but slightly affected.

Similarly we could not hope to treat successfully the cardiac failure induced by perforative peritonitis or repeated profuse intestinal hæmorrhage.

Before going into the question of results it must be fully understood that the use of quinine above indicated is purely supplementary to that of the bath. Under frequent bathing the large majority of cases never show indications of failing circulation sufficient to demand special treatment. But bathing, though a powerful preventive in this respect, cannot to any great extent restore the

heart-feebleness that has already occurred. This is the peculiar advantage of quinine, and accordingly it is in the cases admitted in an advanced stage of the disease that it is of such signal service.

Now the value of quinine as a direct cardiac stimulant has only been fully realized during the last eight-and-a-half months, consequently a consideration of the results obtained during that period will form the best measure of its value.

The cases of typhoid admitted (excluding febriculæ, abortive cases that convalesced before the tenth day, and all those cases that are not yet convalescent) have been 306 in number. Of these 18 have died, which gives a general mortality of less than 6 per cent., but of the 18 deaths 11 were from perforation, 2 from hæmorrhage and 3 from dysentery. In these latter extensive ulceration of the rectum was disclosed *post mortem*, so that in all of the 16 the fatal result was the direct result of the intestinal lesion, and none of them could have occurred in any other fever but typhoid. There remain, therefore, but two to be considered. In one of these death was immediately due to pneumonia. To within 24 hours of the termination of the case no sign of cardiac failure had shown itself, when suddenly pneumonia, involving the whole of the left lung and a great portion of the right, set in with such intensity that the patient succumbed, apparently to a mixture of collapse and asphyxia. There was absolutely no time to obtain the effect of any drug. So rapid was the failure that at the *post mortem* the lungs were found to be still in the first stage of a croupous pneumonia—heavy, engorged, but with no trace of true hepatization. In the other case the cause of death remains a mystery still. The patient, a young girl, had completely convalesced, and had, in fact, been allowed to get up. Suddenly, however, she was seized with high temperature, a painful inflammatory swelling appeared in the region of the right submaxillary gland, and she rapidly died with hyperpyrexia in spite of treatment. The autopsy showed only a small hæmorrhagic infarct in one lung (insufficient in itself to account for death), and the intestinal ulceration was completely healed. The girl had been suffering from sore fingers, and Dr. Forbes attributed the death to septicæmia, contracted from a case of puerperal fever that occupied a neighbouring bed.

Be that as it may, the analysis of the 18 fatal cases shows that during the above period no case out of the 306 has succumbed to the usual form of cardiac failure, which is under ordinary treatment the most frequent mode of death.

So much for the ultimate results. Turning to the clinical histories of the cases it is astonishing

to see how completely the pulse has been under control. In fact, it has seemed possible to set the hearts' action at almost any desired rate (within certain limits), and to maintain this for long periods at will; consequently increasing rapidity of the pulse, from being one of the most unmanageable symptoms of the disease, has almost ceased to cause anxiety.

A pulse of 120 per minute has usually been regarded as on the margin between safety and danger, and accordingly a fairly definite rule for the administration of quinine has gradually evolved itself. Immediately the pulse commences to attain this rate 3 grains of the drug are given every 3 hours day and night. Should no effect be produced in 24 hours the dose is increased to 5 grains or even 7, though the latter is but rarely required. In this way the pulse has been kept below the danger point for weeks together, and this has been done in every case without exception where no unusual complication has intervened, that is to say, the uncomplicated cardiac feebleness of pyrexia is, by this treatment, completely held in check.

In attributing all this to the combined result of cold bathing and quinine but one reservation must be made. In every case where the latter has been used alcohol in small doses has also been deemed advisable. But these are the very cases in which alcohol has always been administered without, however, any such marked effect on the pulse as described above. One thing is certain—that the use of quinine has vastly reduced the consumption of alcohol in the fever wards. It is now quite exceptional for more than 4 or 6 oz. of whisky to be given in the 24 hours, even in severe cases, whereas formerly 8, 12, and even 16 were not infrequently administered.

Some peculiarities in connection with the action of quinine on the heart are worth noting. In the first place the slowing of the pulse rate is late in appearance, 24 hours usually elapsing before it is distinctly perceptible. On the other hand the effect when obtained is somewhat permanent, for if the drug be suddenly withheld the pulse does not attain its previous range for two or three days. This is in striking contrast to its action on the temperature, which is never prolonged for more than 36 hours by even the largest antipyretic dose.

Further, its action is not limited to typhoid, for I have obtained exactly similar results in the last stages of phthisis, in croupous and broncho-pneumonia, and even in surgical cases, where the pyrexia has been due to local suppurations.

I venture to think that the recognition of this use of quinine is in itself of vast importance, and that by it alone many lives might be saved. The

difficulty of successfully meeting the emergency of cardiac failure is abundantly testified to by the number and variety of drugs that have been recommended for its treatment. Among these may be mentioned digitalis, camphor, ergot, musk, castor, carbonate of ammonia, the various ethers and many more. More recently caffeine and cocaine have found supporters. With the exception of musk I have given them all a fair trial without getting the slightest perceptible results from any but digitalis, and in this case such results as were obtained were unfavourable. Quinine, therefore, has come to fill a gap in the therapeutics of fever hitherto unoccupied.

Someone may here say: "But quinine is, by your own admission, the commonest drug prescribed in fever." This is true, but the exact indications for its administration have never been defined so far as I have been able to discover with the limited library at my disposal. * Jurgensen goes nearer to the mark than any other when he states that quinine is a valuable antipyretic and has the great advantage of not injuriously affecting the heart's action.

Consider for a moment how failure to recognize its true effect on the heart might injuriously influence one's practice. All the authorities on therapeutics I have consulted state that quinine is a cardiac depressant, and this conclusion has been drawn from experiments on animals. Suppose that one who is imbued with this teaching prescribes small doses of quinine at the beginning of an ordinary case of typhoid. Later on, in the usual course of events, the pulse becomes weaker and more frequent, the heart sounds less satisfactory. What then happens? Probably the quinine is withdrawn on the supposition that it is weakening the heart's action, whereas this is just the emergency in which the dose should be doubled or even more largely increased. All this has, at any rate, frequently happened to myself.

It is interesting to speculate as to how this action of quinine has been so long overlooked. The fact would appear to be that it is just one of the numerous instances in which the inferences drawn from experimental physiology have been straightway applied to practical therapeutics without previous careful verification. Experiments on animals may be of immense service in pointing out the lines upon which to experiment clinically, but unless their results are made altogether subservient to bedside observation there can be no doubt but that they are capable of leading to fallacy quite as frequently as to a correct conclusion.

* Since writing this paper I have seen it stated that Professor Germain See regards quinine as a heart tonic and prescribes it in large doses in typhoid.

MALARIA AND LA GRIPPE.

By CLIFTON STURT, L.R.C.P., ETC., GOVERNMENT MEDICAL OFFICER, BULLI AND COAL CLIFF, N.S.W.

It is probable, in fact the recent investigations of bacteriologists and biologists all tend to shew, that the so-called infective diseases are due to specific micro-organisms. Their life history is not known, but it is an undoubted fact that some portion of it must be passed outside the human body. They are found in the soil, in air, and in water.

In the soil they probably find all the conditions necessary to their existence. Its varying temperature, its humidity, and the probable presence in it of a necessary food will enable them to thrive and multiply. By the recession of *ground water*, which may in some cases even itself furnish them with a home, they are deposited in the interstices of the surface soil where they are brought into contact with the *ground air*.

The *ground air* rising from the soil may be the means of conveying them into the atmosphere, obeying the movements of which, they are spread over the surface of the globe.

In a similar manner they may be conveyed by water.

Either through the medium of air or water they gain an entrance to the human body, where they become the chief factor in the production of the so-called infective diseases.

The recent demonstration of the presence of amoeboid or infusorial forms of animal life in the blood in malaria points to the agency which micro-organisms play in the causation of this disease.

North, in his lectures on the malarious fevers,* pointed out that the presence of *telluric effluvia* and *some agent* then unknown were factors in the production of the paroxysmal fevers. They occurred within certain districts, and were carried by winds which spread the malarious poison in ascertainable directions.

Malarious soils are not necessarily marshy, but they contain a large percentage of organic matters in a slow state of decomposition, and are subject to both diurnal and annual variations of temperature.

On January 14th, 1890, Professor Klebs,† of Zurich, described certain micro-organisms in the blood of influenza subjects, and pointed out that its spread is analogous to the spread of some forms of malaria.

This is especially interesting at the present time.

* *British Medical Journal*, 1887.

† *Centralbl. f. Bakter.*, vii., No. 5.

If it is true that influenza (*La Grippe*) is due to a specific micro-organism it seems not only possible but probable that its conveyance by means of letters, air and other means is feasible, and measures should be taken to prevent, as far as possible, the spread of the disease through such channels.

A CASE OF ENCYSTED EMPYEMA.

By LESLIE G. DAVIDSON, M.B. ET CH.M.
SYD., RESIDENT MEDICAL OFFICER, SYDNEY HOSPITAL.

L—J—, *ætat* 23, was admitted into J ward of the Sydney Hospital on Friday night, February 21st, 1890. Patient is an engineer on one of the large steamers. He has made two voyages with the ship, and has lived mostly in England. He resided in Turkey for a short time. Family history good. He has hitherto been a healthy man. He is rather pale in the face, but does not look very ill. He is well nourished, and his pulse and respiration are of normal frequency. The surface of his chest over the liver has been painted with iodine. His temperature is 99 deg. F. The tongue is clean. The appetite is not good, and he does not sleep well. He sweats a little both day and night.

February 23rd.—Patient states that he has been ailing for about a month. At that time he had diarrhoea, the bowels being moved three or four times a day. This condition got better under treatment. For the last week he has complained of an aching pain in the right lumbar region.

Palpation in this situation is painful to the patient.

Circulatory system.—Apex beat of heart is in normal position; sounds are clear.

Urinary system.—The urine had a specific gravity of 1020; was acid and contained no albumen.

Respiratory system.—Front of chest: Respiration is quite normal in the front of the chest. He has no cough, and deep inspiration is not attended with any pain. He does not complain of shortness of breath; chest expands well.

Laterally.—On percussion of the right chest, laterally, loss of resonance is found from about the 6th to the 8th rib. Posteriorly there is loss of resonance just above base. The breath sounds in this area are weak, and both vocal fremitus and resonance are diminished, although both can be obtained. There is no aegophony. There is no oedema of the chest wall in this area. The skin over the chest in this area is tender on per-

cussion. There seemed to be lessened expansion of the right chest at the base. Although he had no very great rise of temperature (99.4 deg. F.) or definite symptoms of fluid, a needle was inserted between the 7th and 8th ribs in the mid-axillary line, and pus was obtained. The pus was thick and quite sweet. Dr. Goode saw the patient on the same day. The patient was then etherized, and an incision made in the mid-axillary line, between the 7th and 8th ribs. A portion of the 8th rib was removed with the bone forceps. After removal of the piece of rib from 6 to 8 ounces of thick pus welled out; it had no odour. On putting the finger into the chest it came in contact with a cyst-wall from which flakes of pus could be detached. The cavity was about 2½ inches deep. There was no communication with the diaphragm. The cavity was syringed out with a solution of iodine, a drainage tube inserted, and the wound sewn up around the tube.

The following notes were made by Dr. Kelly: February 24th.—Cavity washed out with iodine; very little discharge. Morning temperature, 99 deg. F. Has a cough which gives him pain.

February 25th.—He feels very well to-day. Temperature in the morning, 98.4 deg. F. Cavity washed out as before. Scarcely any discharge. Cough is troublesome.

February 27th.—Cavity washed out; rather more discharge. Pulse, 120. Temperature, normal. Dulness around cyst with tubular breathing and aegophony.

February 28th.—Washed out to-day; not much discharge. Patient looks and feels much better. Has an evening rise in temperature. Pulse, 120. Temperature this evening, 99 deg. F.

March 8th.—Cavity almost closed up. Tube taken out. Wound dressed with boracic ointment. Evening rise of temperature has ceased. Patient looks well and has a good appetite. Temperature on March 6th, 100 deg. F. (evening).

March 31st.—Patient discharged to-day quite well, the wound having completely healed. Patient has gained weight, and has a good appetite. His temperature has been normal since the 7th of March, and he has no cough or sweats. The chest expands well. There is still some dulness around the cyst with weak breath sounds and diminished vocal resonance.

Remarks.—This case is interesting from the fact that he did not complain of any chest symptoms, and referred the pain to the right lumbar region. His temperature did not go beyond 99.4 deg. F., and he had no cough. It also illustrates the advantage of using an exploring needle in all doubtful cases.

PRIMARY CANCER OF THE MAMMA AND TONGUE. SECONDARY DEPOSIT IN UPPER SET OF DEEP CERVICAL LYMPHATIC GLANDS.

BY ALEXANDER MACCORMICK, M.D., HONORARY SURGEON, PRINCE ALFRED HOSPITAL, SYDNEY.

For the following notes I am indebted to Dr. Mills, House Surgeon.

M. W., female, aged 36 years, married, engaged in domestic duties, was admitted to Prince Alfred Hospital on the 19th March, 1889, under the care of Dr. MacCormick.

She states that about four months ago she first noticed a brownish fluid exude from her right nipple, and on examining the breast she felt a small lump. She does not think the lump has increased in size since she first noticed it. At odd times she has had pricking pain in it. She never had any inflammatory trouble with her breast.

She has always enjoyed good health. She has had one child, which she suckled. Her family history is good.

On examination: patient is a very spare woman and she looks in very fair health. In her right breast there is to be felt a rather hard irregular mass about the size of a pigeon's egg just above and outside the right nipple. The mass is freely moveable on the pectoralis major. One enlarged gland can be felt at the apex of the right axilla. All her organs are healthy. On the 21st March, 1889, patient was anesthetized. An exploratory incision was made through the mass. It was found to be a scirrhus. The whole breast was thereupon removed, the fascia over the great pectoral muscle being dissected off at the same time. The axilla was opened and the cellular tissue with the lymphatic glands removed *en masse*. These glands were found to be hard, shotty, and infiltrated. The edges of the wound were then approximated with deep wire sutures and superficial horsehair sutures. Two drainage tubes were inserted, one through skin of posterior axillary wall, the other at the anterior edge of wound. Dry dressing was applied.

The wound healed by first intention. The temperature never rose beyond 99° F., and patient was discharged cured on the 9th April, eighteen days after the operation.

On the 2nd October, 1889, patient was re-admitted complaining of a lump on the right side of the tongue. She first noticed a small pimple on the site of present lump about five months ago. She thinks the pimple was caused through the rubbing

of a broken tooth against her tongue. The tooth was removed, but the pimple increased in size. Thinking the lump might be of a syphilitic nature, she was put under the usual treatment. This had no effect and the lump continued gradually to increase. On examination of tongue there is a hard mass occupying right side of tongue about its middle for an inch of its extent. A superficial granulating surface is to be seen over the lump. No enlarged glands to be felt. Patient still appears in fair health, and suffers little or no inconvenience from the state of her tongue.

On the 11th October, 1889, under chloroform, the tongue was removed well beyond the lump with scissors. The lingual arteries were seized as they came into view, and there was very little bleeding. The stump of the tongue was then drawn forwards and sutured to the cut edge of the mucous membrane of the floor of the mouth with catgut sutures.

Patient was fed by means of soft indiarubber tube passed through the nose into the gullet until the wound in the mouth healed, which it did by first intention. There was no rise of temperature, patient was up five days afterwards, and was discharged eighteen days after the operation. She was then able to speak fairly well and had no trouble with her saliva. She could eat and swallow very well.

An examination of the tongue shewed the lump to be of a scirrhus nature.

On 11th February, 1890, the patient was re-admitted to hospital complaining of a small lump in her neck below the angle of her right jaw. She first noticed this lump three weeks before admission. It had grown rather rapidly. It was not painful, but rather tender.

On examination the lymphatic glands behind the angle of the right inferior maxilla are felt to be hard, enlarged, and not freely moveable. No other of the glands can be felt enlarged. Her health has been good since date of last discharge. She speaks and eats well and suffers little inconvenience from having had her tongue removed. On 17th February, 1890, patient was placed under chloroform and an incision made along the anterior border of the sterno-mastoid muscle for about three inches and over the side of the enlarged glands. The dissection was carefully carried on until the fascial covering of the glands was reached. The lower part of the gland mass was found not to be adherent to any great extent to the surrounding tissues, but the upper part was closely adherent to the internal jugular vein, the ninth and vagus nerves, all of which were completely freed from the glandular growth. The glands were then removed in one mass. From

the middle of the incision another was made in a transverse direction so that the submaxillary lymphatic glands might be exposed. They were found to be slightly enlarged, and with the submaxillary salivary gland, were removed. The facial artery and vein were cut and tied. Wound was closed with horsehair sutures, a small drainage tube put in at lower margin of wound and dry dressing applied. Wound was dressed again on the 22nd February and tube removed; temperature has never reached beyond 98·6° F. Patient was discharged cured, twelve days after the operation.

PROCEEDINGS OF SOCIETIES.

SOUTH AUSTRALIAN BRANCH OF THE BRITISH MEDICAL ASSOCIATION.

ORDINARY monthly meeting, held at the Adelaide Hospital on March 27th, 1890. Present: Dr. Cleland (President) in the chair; Drs. Bruehl, Clindening, Way, Bickle, Niesche, Symons, T. K. Hamilton, Cookson, Gregerson, Swift, A. A. Hamilton, London, Jay, Ewbank, Hayward, and the Hon. Sec.

Dr. Michie was present as a visitor.

DR. SWIFT showed, for Dr. Todd, a lad, the subject of extensive ulceration of the mouth and throat.

The minutes of the previous meeting were read and confirmed.

DR. GREGERSON, a new member, was introduced to the President.

Papers on Extra-uterine Pregnancy were read by Drs. R. H. Marten, H. Swift and Ed. Way, and a discussion followed in which the authors of the papers, Drs. London and Bruehl, took part.

A CASE OF EXTRA-UTERINE FŒTATION CURED BY THE APPLICATION OF A STRONG FARADIC CURRENT.

By R. HUMPHREY MARTEN, M.B., B.C. CAMB.,
M.R.C.S. L.R.C.P., LOND.

THE case which I wish to bring before this Society is one of great interest, not merely from its successful termination, but with a hope that it may help lead to a useful discussion on what must be looked upon as one of the most serious accidents that can befall a woman during her child-bearing life. When it is known that the death-rate averages 67·2 per cent., according to Parry's statistics, and that it is the great cause of those appallingly sudden deaths in women, it is only right that we should obtain any information with regard to successful cases or others which may help to alleviate the sufferings to woman in connection with the transmission of life. The history of my case is as follows:—A lady, æt. 41,

the mother of five children, last confinement 18 months ago, always of a weakly constitution, and in her younger days had suffered from lung trouble with hæmoptysis; had typhoid fever when seven, followed by paralysis of the right leg and left arm for one year; with a good family history except for asthma on the male side.

Present Illness.—Quite well till August 10, then missed her monthly period, but had no other trouble except dyspepsia and swollen and painful mammae, which led her to suppose she was again pregnant. On September 20, just 40 days from missing her period, she was suddenly taken with a most severe stabbing and, as patient herself described it, a "commanding pain," starting from her right loin and shooting down to the pubes, attended by flatulence, feeble pulse and great collapse. I took this to be an attack of renal colic, and at the end of half-an-hour under appropriate treatment the pain cleared away. On September 27 had a more severe attack, which kept patient in bed till September 30. On October 4 another and still worse attack came on, but still nothing appeared wrong in the urine, and in between the attacks patient was quite well. No more attacks occurred now for over a month, when, on November 9, whilst out of town a very alarming attack occurred, and again on the 11th, during which time she was attended by a medical man. Began on November 2 to lose blood by the vagina, and had a continuous red discharge with large clots, but no membrane as far as patient's observation went. The discharge ceased on November 14. On November 15 kept well all day, and only felt weak from losing so much blood. About this date patient was very much worried about family affairs; at 7 p.m. taken again with the awful pain, rather more difficult than before but always starting from the right kidney—this came on whilst walking upstairs, and when I saw her she was utterly collapsed, pulseless, covered with a cold sweat, moaning with the severe abdominal pain, which was soon relieved by a hypodermic of $\frac{1}{4}$ gr. of morphia, and followed by a good night. The severity of the pain made me think there must be something more than a renal calculus, especially as the urine showed nothing abnormal. On the following morning I examined her per vaginam and found the uterus somewhat enlarged and pushed over to the right side with a rounded, fluctuating, tense, extremely tender swelling in the left broad ligament, about the size of the closed and apposed fist, fixed with the vessels on this side of the vagina, much larger and more pulsatile than on the right side. I could not define the swelling from the outside, owing to the pain causing rigidity of the recti. From the history and symp-

toms I suspected an unruptured extra-uterine foetation in the left broad ligaments.

On November 17 I got Dr. Gardner to see the patient with me, and he agreed with my opinion and recommended putting her under ether, which we did, and passed the sound rather over two and a half inches into the uterus, which we found to be fixed to the left broad ligament. With a binaural stethoscope inserted into the vagina a loud humming bruit was audible over the swelling, but not present on the opposite side. For four weeks patient had been suffering from diarrhoea, but no blood, stools giving rise to such intense pain and making patient so faint that she dare not go to the closet without someone else being present. At this consultation we determined, for reasons which I will afterwards state, to apply a strong faradic current to the tumour.

November 19, 8 a.m.—Patient again put under ether and one rheophore was inserted into the vagina right up against the cyst, and Apostoli's abdominal rheophore placed over the left inguinal region, the whole current from a two-inch dry coil of a faradic battery from two large bichromate cells was passed through the swelling for five minutes. This created a perfect tetanus of the whole of the muscles of the body, causing opisthotonus, requiring Dr. Gardner, myself, and three nurses to hold her down in bed, in spite of being fairly well under the influence of ether all the time. It is needless to state that we ourselves took great care not to make any contact among us.

On November 20 patient felt as though someone had beaten every muscle in the body, otherwise she was free from pain or bad symptoms.

On 21st, 22nd, and 23rd was in good spirits and had no pain, ate and slept well. Had no pain except on defecation and increased frequency of micturition; looked much better.

November 24.—Examined swelling, which was certainly no larger, if anything slightly smaller, and not nearly so tender. Has very little trouble with bowels or urine. No flatulence. Breasts now quite comfortable.

December 1.—Seen again by Dr. Gardner, when we came to the conclusion that the swelling was a great deal smaller, not now tender, and the bruit, which had been audible thirteen days before, had now quite disappeared. There had been a very slight attack of pain since the battery, and all bowel and urinary trouble had ceased. She was taking her food extremely well and looked very much better. Has never had the slightest rise of temperature since first coming under observation.

On December 22, a little over a month from the time of the application of the battery, we re-examined patient and found the swelling still

smaller. We now allowed patient to get up for the first time.

On March 2 I examined her again and found only a thickening in the left broad ligament, and since then patient has sailed for Europe in excellent health.

I think the points of interest in this case are the very successful ending of such a frequently fatal complaint, which is due in part to our comparatively early diagnosis and simple treatment.

With regard to extra-uterine foetation, we may divide them according to Reeve in the *International Journal of Medical Sciences*, into three classes:

1. A small number which run on to full time and end in a spurious attempt at labour before their true state is discovered.

2. A somewhat larger number which are seen for the first time when rupture of the cyst has occurred and death by shock and hæmorrhage speedily ends the scene.

3. A large majority of cases in which marked symptoms are present from an early period and in which a diagnosis may be made.

With regard to diagnosis, first we have those of the probable existence of pregnancy, such as digestive changes, changes in the breasts which lead patient to believe she is pregnant. Lawson Tait, who has had far more experience than any living surgeon on such cases, does not lay much stress on these points, although other observers do so. As a rule in extra-uterine pregnancy a long period of barrenness precedes the occurrence, but this was not the case in my patient, as only thirteen months before I had delivered her of a full-term child. There had never been any history of desquamative salpingitis, which Lawson Tait considers to be the prime factor in these cases.

Next to the reflex symptoms come those of menstruation, there may be as usual amenorrhoea, or irregular discharges of blood with at one time or another a decidum; my patient may have passed this unobserved during her long period from November 2nd to the 15th, but I never got hold of it, and it may have come away in shreds, anyway if it is obtained it is hardly necessary to state that it is of the very greatest help.

By vaginal examination the uterus is found somewhat enlarged, but not so much as would be expected from the duration of the supposed pregnancy, and it is generally pushed to one side by the cyst. The sound when passed, after metrorrhagia has occurred shews some lengthening of the uterine cavity, as it did in my patient. The tumour is felt to be round, elastic, fluctuating but tense, tender and fixed to the uterus, with large pulsating vessels on its surface which give rise to a bruit, and later on ballottement may be obtained.

In addition to these symptoms the terribly sudden attacks of such excruciating pain, coming on at irregular intervals, leads one to suspect something out of the ordinary way. I think the attacks my patient had were the worst I have ever seen anyone suffer from. These are supposed to be due to contraction and partial rupture of the cyst wall.

Although the above symptoms seem pretty clear, it is a very well-known fact that cases are rarely diagnosed before rupture has taken place, and Lawson Tait, who has seen 75 cases, has only once diagnosed one before rupture has occurred, and used to throw doubt on any case which was reported. Cases which may be confounded with unruptured extra-uterine foetation are, abscess of the broad ligament, pelvic hæmatocele, retroversion of the gravid uterus, ovarian or dermoid cysts, parovarian cyst, tubal disease, as pyro-salpinx, pregnancy in a uterus, bicornis intra-uterine pregnancy, but by careful observation of the temperature, pain, rate of growth, and position of these tumours a correct diagnosis may be arrived at.

With regard to treatment: If the cyst has ruptured and is intraperitoneal there is nothing left but laparotomy, unless when the patient recovering from the primary shock is left to the extremely dangerous method of getting rid of the foetus by suppuration and bursting of the abscess into the bowel, bladder or externally, ending in a tedious convalescence. I think nowadays, after Lawson Tait's brilliant success of forty cases and only two deaths, no one would leave a patient to so miserable a death.

In the unruptured cases the treatment may be varied. First and foremost comes electricity, and best of all a strong faradic current, which may be applied more than once if necessary. This is better than puncturing with electrodes connected with a galvanic battery, as in this you may set up suppuration. The only danger with the faradic current is the fear of rupturing the cyst wall, which contains much muscular tissue of the broad ligament, but if such an untoward accident should happen, laparotomy may at once be performed with a very fair hope of success. If electricity be discarded primary laparotomy may be performed.

With regard to the treatment by electricity there are some surgeons who hold, even at the present day, that if the case is so cured it was one of mistaken diagnosis. But I think there is very little doubt that our diagnosis was correct and the treatment sound. There are two great reasons why we decided on electricity—one, owing to its simplicity, and two, chiefly owing to the

very precarious state of our patient at the time, which, in consultation, we decided would render her very unsuitable for surgical interference.

In this paper I have made free use of Reeves' article, as quoted above, in Vol. iv. No. 1 of the *International Journal of Medical Sciences*.

Fifteen weeks elapsed from the time the last period occurred till I had my suspicions aroused. This, I am afraid, is rather long, as one case is recorded at the end of five weeks and another at thirteen weeks. But it does not so much matter now as we got the case before rupture occurred, and I hope that if I ever get another case like it to be able to make a quicker diagnosis.

I cannot conclude this paper without thanking Dr. Gardner for his very great assistance and skill he brought to bear on the case from the time I called him in consultation.

NOTES ON A CASE OF SUPERFŒTATION—UTERINE AND EXTRA UTERINE.

By E. WILLIS WAY, M.B., M.R.C.S., GYNÆCOLOGIST ADELAIDE HOSPITAL, AND LECTURER ON DISEASES OF WOMEN, ADELAIDE UNIVERSITY.

MARY BRANDSTROM, age 32, married, admitted to the Hospital on Jan. 6, 1890, with an enlargement of the abdomen.

She stated that she first noticed the swelling 12 months ago, and then thought she was pregnant. Last April she consulted a medical man, who told her she was pregnant, and she also thought she could feel the movements of the child. The tumour at first was in the median line, but it is now situated rather to the right, extending upwards for about two inches above the umbilicus, the most prominent point being a little to the right of the umbilicus. The tumour is smooth, elastic, and well defined, with doubtful fluctuation. It is dull on percussion.

Menstruation.—During the first 8 months of the year the menses were absent, but came on again two months in succession, and since October on one occasion she had a slight menstrual discharge.

She states she has been getting much thinner and weaker lately, and at times has some pain in her abdomen and across the back. Urine is passed freely, but rather more frequently.

The tumour increased gradually in size for the first 6 or 7 months, and then seemed to get much smaller. It again further increased in size during the last month or two, and now feels heavier.

Measurement of circumference of abdomen at the level of the umbilicus: 30½ inches.

On per vaginam examination: the upper part of the pelvis is occupied by a smooth, firm, elastic swelling, continuous with the abdominal tumour. The cervix looks downwards and backwards, and admits the tip of the finger.

The uterus is not moveable, and is apparently continuous with the swelling. The sound passes 3 inches backward and upwards behind the pelvic swelling. Blueness of the cervix and vagina is marked. Mobility of the tumour is very limited.

Jan. 13, 1890.—The patient again examined to-day; sound passed $4\frac{1}{2}$ inches.

Jan. 22nd.—A good deal of blood has been discharged per vaginam; it sometimes comes away in dark clots, and sometimes the blood is bright red; pain comes on, which she describes as being like labour pains, after which blood is discharged; this commenced on the 20th and has continued ever since; the os is more patulous, and the finger can be passed up to the internal os.

23rd.—Ether was given this morning, and the uterus dilated with Hegar's dilators and Barnes' bags; a foetus was extracted, apparently about 4 months, placenta was removed, and hot water injected to arrest hæmorrhage, which was rather free; hypodermic of ergotine then given. The tumour in the right side of the abdomen still remains, but is somewhat diminished, being lower and more confined to the right side of the abdomen.

25th.—After the operation the temperature sank to nearly normal, having on the previous day risen, and reached 101.2° at night; the temperature again rose on the evening of the 24th, and in consequence, at the visit on the morning of the 25th, I ordered carbolic acid internally, fearing the existence of septic absorption from the operation.

26th.—Patient had a rigor last night; vomited frequently; abdomen is distended.

27th.—Owing to the signs of septic peritonitis she was again examined by Dr. Way, and some small fragments of placental tissue removed by the curette; several clots and some blood came away; uterus washed out with an antiseptic solution. Temp. 104° in the evening; pulse, 144. Uterus washed out again in the evening; some dark coloured fluid, but no clots, came away; vomited after taking an antipyrin powder.

28th.—Temp. 102.4° this morning; has frequent vomiting; the tympanitis has markedly increased.

30th.—Vomiting and abdominal distension have increased; feels pain in her abdomen. She gradually sank and died on the morning of the 1st February.

The following points in Mrs. B.'s history have been kindly supplied by Dr. Stewart:—She had

been married seven (7) years and had two children, one now four years old, the other, born two years ago, died at four (4) months, of marasmus. In November, 1888, she had a "miscarriage" at two months. In February, 1889, thought she was pregnant, and in April of that year Dr. Burke, of Melbourne, told her he could hear the foetal heart.

Post-mortem.—On opening the abdomen a quantity of gas escaped. Peritoneal cavity contained a large quantity of greenish yellow fluid. A tumour was seen occupying the lower part of the abdomen, rather more on the right side than the left, partly adherent to the abdominal parietes and extending into the pelvis. Omentum and intestines firmly adherent to one another and to the tumour. The tumour consisted of a sac in connection with the right fallopian tube which could not be defined, which contained a foetus about 12 inches long. Foetus rather soft and undergoing maceration; the internal walls of the sac were partly broken down and dark in colour, the sac also contained the placenta with cord attached. Some small perforations in the walls of the sac allowing escape of fluid into the peritoneal cavity were present. Uterus about 4 inches long, the site of a placenta recently removed could be seen; internal surface of the uterus clean, no discharge from uterus. Left ovary and tube could be traced, apparently normal; other organs healthy.

TWO CASES OF RUPTURED TUBAL PREGNANCY.

By H. SWIFT, M.D. (CANTAB), &c.

Mrs. S—, æt. 30. Two children. Never a very strong woman. In May, 1888, we received an urgent message to go and see her as she was said to be very ill with pains in the stomach. She was seen and a sedative mixture prescribed. In the middle of the same night her husband came and said she was much worse, and he was afraid she was dying. I found her pale, weak, and complaining of pain on right side of abdomen low down. There was some fulness and tenderness in right iliac region. She thought she was pregnant in the fourth month, but could not understand her condition, as she had been poorly a little the previous week. There was no discharge per vaginam, but, upon examination, I found a considerable bulging to the right of the uterus, which was pushed over to the left. The pain had come on very suddenly, and was very severe at first.

I thought it possible that she had a ruptured ectopic pregnancy, and ordered her strict rest in recumbent position and opium. She was a little

better the next day, with less pain; abdomen in same condition. On Tuesday, two days afterwards, she was suddenly seized again with violent pain, and when I saw her half-an-hour afterwards she was blanched and almost pulseless. I was then quite certain of the diagnosis, and discussed with Dr. Todd the advisability of immediate operation; but, owing to her extremely low state, we considered that it was safer to wait and let her pick up a little before submitting her to the further shock of an abdominal section. She rallied and improved daily, and we had decided to see her on Sunday and arrange about the operation. On Sunday morning, at 9 a.m., I received a message to go to her at once. Upon my arrival, at 9.30 a.m., she was dead. She had been seized suddenly with great pain, became rapidly pale and faint, and died just before I arrived. At the *post-mortem* examination the same afternoon we found a large quantity of blood in the abdominal cavity and a foetus about twelve weeks, which had escaped from a rent in the right tube. Adherent to the posterior surface of the dilated tube and just internal to the rent was a quantity of firm and partly organized clot, which was evidently the result of a hæmorrhage a few days previously, giving rise to the first urgent symptoms, and which also showed an effort of nature to repair the breach. There was plenty of room between the uterus and the pregnancy to pass a ligature round the ligament.

I very much regret that I waited until too late.

On March 27th, 1889, at 12 o'clock, I was called to see the body of a girl, æt. 19. Upon arrival it was quite cold except in legs. The people with whom she had been living stated that she went to bed perfectly well and in her usual robust health as far as they could judge. She made no complaints. In the night the wife thought she heard a groan and someone walking about, but took no notice. In the morning the girl was found to be ill, complaining of pains in the stomach which had come on suddenly during the night. Hot fomentations were applied, but, as she was getting worse and was pale and faint, at 10 o'clock the wife went to fetch the girl's mother. When they returned she was dead.

At the *post-mortem* the abdominal cavity contained a large quantity of blood, and upon exploring the left ovarian region I found the source of the hæmorrhage, and the specimen before you which has been so skilfully prepared and mounted by Professor Watson.

DR. WAY did not understand why Dr. Marten had not done a laparotomy in his case, considering the imminent danger of rupture into the peritoneal cavity.

DR. SWIFT thought that diagnosis was the chief difficulty, and one which could not always be cleared up without a section. He had once operated on a woman supposed to be pregnant, with a large swelling in the right iliac fossa. This case had some resemblance to the one read by Dr. Way that evening, but he found a pregnant uterus and a dermoid cyst fixed to the broad ligament. The woman did well. He (Dr. Swift) didn't think the electrical treatment either simple or safe.

DR. LONDON mentioned, in illustration of the difficulty in making a correct diagnosis of extra-uterine foetation, a case in the wards of the Adelaide Hospital some three years ago, in which there was an abdominal tumour with apparently some ascitic effusion. In order to examine the tumour better he decided to draw off the ascitic fluid by aspiration, but failed to obtain any fluid at all. This circumstance put him in mind of a case he had under observation at the Middlesex Hospital several years before, which turned out to be colloid cancer of the omentum. However, at a subsequent consultation, one member of the staff present introduced the whole hand into the rectum, and thought that he felt distinctly foetal limbs, and thereupon it was decided that the case was most probably one of extra-uterine foetation. The patient died, and the *post-mortem* examination revealed extensive colloid infiltration of the peritoneum.

DR. MARTEN did not do a laparotomy because he thought it best first to try the simpler method of electrical treatment. The condition of this patient was, it was true, rather alarming during the passing of the current, but immediately after its cessation she had no symptoms of distress. With regard to Dr. Way's remarks, he had everything ready and was prepared to do a laparotomy had anything gone wrong. Dr. Aveling had used electricity successfully in twenty cases.

DR. BRUEHL spoke strongly in favour of abdominal section in all cases where extra-uterine pregnancy was strongly suspected, and asked Dr. Way if he had not considered its advisability in his case.

DR. WAY explained that the symptoms of his case after the miscarriage appeared at the time to be those of a septic peritonitis, due to the miscarriage; that was why he had not subsequently made an abdominal section. It was not till shortly before her death that her symptoms pointed to grave danger.

NEW SOUTH WALES BRANCH OF THE BRITISH MEDICAL ASSOCIATION.

THE Tenth Annual Meeting of the branch was held in the Royal Society's room on Friday, 7th March, 1890, at 8.15 o'clock. Present: Dr. Fiaschi, President, in the chair, Drs. Jarvie Hood, Williams, Crago, Knaggs, Williams, Wm. Chisholm, Jenkins, Ellis, Quaife, W. J. O'Reilly, Cohen, Graham, McDonagh, Marano, Chambers, Worrall, Rennie, Cotton, Wright, Brady, A. T. O'Reilly, Hankins, Hodgson, Scot-Skirving, Lyden, West, Shand, Megginson, Kendall and Clubbe.

Visitors: Dr. McClelland and Mr. Storey.

The minutes of the previous annual meeting were read and confirmed.

The PRESIDENT announced the following new members: Dr. Douglas and Dr. Ford Hughes.

DR. FIASCHI (the retiring President) read the following

PRESIDENTIAL ADDRESS.

GENTLEMEN,—In welcoming you to this meeting, the first of the second decade of our Branch's life, I will briefly put to you an account of what has been done during the last twelve months.

Five council and nine general meetings were held; papers were read on many different subjects—general medicine, surgery, gynaecology, obstetrics, toxicology, and the specialities of the nose and ear—each received their contributions, and the various authors of these, who thus helped the productive work of our Society, are in alphabetical series as follows: Drs. Bowker, Brady, Chambers, Crago, Creed, Foreman, Hankins, Hood, Marano, Morgan, Martin, Milford, Quaife, Scot-Skirving, Todd, Twynam, Williams, Wilkinson and Worrall. Interesting exhibits of various subjects were also shown. The statistics of our Society are as follows:—Death has deprived us of three members, and to these—Drs. Nott, Jas. Smith, and P. MacDonagh—let us in passing bestow a tribute of thought and remembrance. Three resignations were sent in, and fourteen new members were elected, giving us a total of 129 members now on the roll, the largest number as yet attained. The above-mentioned facts by themselves would be abundant proof that on the attainment of its eleventh year of life our Branch is showing signs of vigorous development. In addition I will tell you that at all our meetings there has been a good attendance, and every paper read by its author has brought forward lively and exhaustive discussion, in which almost all the professing members of our congregation, if you will allow me so to call them, have taken active part. Better still, the laudatory style of comment that used to prevail in the earlier years of our existence as a society has given way to a more breezy and healthier criticism. Every year we realize more and more our responsibility as auditors that any opinion expressed in our midst should not be allowed currency unless it meets with our full approval. Silence means consent, and no timidity or misunderstanding regard to person should restrain us from expressing our views even if in dissent. The aims of our science are too high, and the character of us all as medical practitioners, from long training and friction with the stern realities of life, too imbued with heroic spirit to flinch from taking or giving searching criticism. Improvement in this respect is a sure sign that our branch is cutting its permanent teeth, and that in course of time we shall develop into one of those august medical academies, whose collective view on matters of doubt is an authoritative decision.

Proud then of your progress, you will excuse me if I do not fall in with the custom of my predecessors, and spur your flank to increased efforts, both as professional men and members of our society. You still remember a little physiology, and you need not be told that stimulation is not always good, that inhibition is a function to be respected, and capable at times of great good. The fact is, that in one of the most able addresses delivered during the last few months, Dr. Gairdner's plea for thoroughness, he starts with the description of a medical automaton, supposed to be invented by a Dutch apothecary, a wooden figure in the shape of a man, covered with compartments labelled with the names of various ailments. The sufferer has only to place a piece of money in the compartment upon which the name of his illness is

inscribed, and forthwith will appear a pill or powder suited to his case. From this description Dr. Gairdner proceeds with exquisite humour and logic to show that, in matters of health and disease, there is no possible substitute for the living man as a counsellor.

Thoroughly agreeing with Dr. Gairdner's conclusion, I will, however, borrow from him his medical automaton and start with what I have to say to you from it. How many sermons, good and bad, are not delivered on the same text, and the text gets none the worse for wear? *Volens aut Nolens*, the medical practitioner before the public, is very much in the same position of the automaton; down goes the coin, golden I hope, and out must the advice or executive treatment come. The difference with us is that at the meeting point of the afferent and efferent lines, a most delicate and elaborate piece of machinery is located, and that is a medical mind. To that as an instrument I wish for a few minutes to direct your attention. I will, however, say that as a medical mind I wish to consider only the fully developed practitioner properly educated and fully equipped with the necessary knowledge, and with a certain amount of previous experience. In considering this delicate instrument we first find the part that receives the statement of the patient. What sharpness and readiness of perception is not required? That eye that sees where ours cannot, the photographic plate cannot beat it in sensitiveness or promptness. A faint abnormal sound, a slight blur in the speech of your patient, a difference in the complexion, maybe a paleness, a yellowness, or a mere general greasy look, the innumerable differences of the pulse under the touch, the boggy or hardness of a tissue, the fluctuation, the wave, a peculiar odour even, may be all the clue that in some cases may help us to get a correct diagnosis. These must be promptly seized, and not always are they easy to get, not always have we patients who in seeking advice throw themselves open to investigation both by word and by physical sign. On the contrary, in many instances we are thrown off our scent either through ignorance, or prejudice, or design. The delicate instrument that I am describing is fully equal for all that; and no sooner the impression is received, clear or mixed up, a process of sorting sets in; the valuable evidence is retained, the useless cast out, just as the miner's cradle retains the golden dust and allows the sand to be washed off. But how many compensations and corrections are required in this central portion of our instrument—the judgment—to obtain correct conclusions. Prejudice or pre-conceived ideas may be in our way, undue haste may prevent us from collecting all the evidence required, and sometimes force of habit may lead us into ruts that may render the working of our machinery in a particular case useless. All these causes of error and many more have to be eliminated, and only then is the clear conception of the nature of the patient's illness evolved, when the outgoing process begins. In this culminating position judgment is still at work and must find out its way in the entangled mesh of treatment. An eminent French professor of agriculture had in his lecture-room printed these words: "There is nothing certain in Agriculture." The same apply exactly to our pursuit in regard of treatment, not a week passes but each of us has cause to verify the glorious uncertainty of Medicine. Judgment must here again use all its most delicate balancing to find in the wide field of Therapeutics that treatment the best adapted to our case, and to our patient's individuality as regards age, sex, diathesis and possible idiosyncrasies. Once this resolved how often is the steady pressure of Will required to overcome the one thousand and more difficulties that prevent the thorough

carrying of the treatment to be adopted. Nor will I expand on the steadfast resolution required to guide your eyes and hand in the execution of it. In very many cases all these steps in the working of the medical mind must be, if not instantaneous, very rapid. The description of the medical mind as given would be incomplete, and would resemble a stringed instrument with chords and resonant body, but not tuned, if I omitted to mention another power required to guide and regulate this complex machinery, and which I hardly know how to cull, whether tone or temper, or better still the unquenchable flame, that is not love of gain nor of self aggrandisement but a mixture of professional pride, of sense of duty, and of philanthropical spirit.

Possessed then as each of you are with an instrument so productive of physical and moral good to others, so slow and costly to develop, so capable with a little good will of constant improvement, I wish you to remember that it is a piece of machinery a long way ahead of the simple automaton described by Dr. Gairdner, but still an instrument with all its completeness and elaborateness.

As such it can only do work under certain conditions, and if due care is not paid to them the wheels will clog, the working become imperfect, and the public will receive only a poor return for the coin put in the slot. What these conditions are I leave you to find out, there being difference in them according to individuals, etc. One only I will mention as more or less common to all of us—I mean *overwork*. And I lay stress on it, for I fear it is the besetting enemy of the greater part of practitioners in Australia. In one of Lever's works he classified chess players according to the various professions, and referring to medical men he says they make poor chess players; the reason of it being that they are accustomed to cases. They make cases out of everything, and disjoin the unity of thought required in the tactics of chess playing, by making a case for the bishop or for the queen, and so on, with their attending remedies. Without discussing the truth of this view I must plead guilty to the irresistible tendency of making a case in the present instance. Having laid out that overwork is one of the most important causes of imperfection in the working of the medical instrument (for of other etiological movements due to a man's own folly I fully believe no allusion is necessary amongst you), I must suggest for the evils resulting prophylactic and curative treatment. The first comes as a logical consequence, and in this I hope my words may act, as I promised a healthy inhibitory influence to you. These are:—restrain yourselves in your zeal for work; sacrifice quantity for quality; economize your power, and nothing will help you so much to do it as method.

The second—although we hardly believe in specifics now, I consider almost as amounting to one—whenever callousness, discouragement, and a tendency to scepticism clogs your mental machinery, remember that there are two sister medical societies in Sydney, whose meetings recur as regularly as the phases of the moon. Attend these. Hardly any mental preparation is required for them; and the healthy stimulus of mental contact with your professional brethren, and the discussion of matters that have for years been the main object of your thoughts, will give new elasticity to the springs of your mental instrument. All that we possess, either physically or intellectually, has been given to us by others. Our best ideas, and those that we consider most as our property, are only the fresh combination of transformed and disintegrated ideas that have filtered in us from other men's minds. It is a

mistaken, mental pride to think that we can retain our stock of knowledge, or make it productive of fresh ideas, unless we seek fresh impetus by communing with our brother workers.

In making my bow to you I must express the different feelings that I experience:—pleasure, for relinquishing a noble office for which I felt myself particularly ill-suited and undeserving; and regret, for leaving a rudder that I was supposed to use, but which, through your kindness, and through the support of the Secretary and other officers, has been a sinecure, and the means of a pleasurable drifting with the current on a placid and vivifying stream.

DR. CHAMBERS said he had listened with more than ordinary interest to the address of Dr. Fiaschi, and it will, no doubt, be the pleasure of the members to accord him a hearty vote of thanks. If we could only take home half the thoughts suggested by it we shall have done well by being here to-night. There is no doubt overwork with many of us leads us into hurrying over our work and not paying that attention to details which we should do. If we could only follow the suggestion to take part in the discussions of this branch, we should all reap a benefit as he (Dr. Chambers) had never attended any meeting of this description without carrying away some thoughts of value. It is very gratifying to see so large an attendance of members, as on one occasion he (Dr. Chambers) remembered having to go out and get a sufficient number of members together to form a quorum.

DR. KNAGGS seconded the vote of thanks, which was carried by acclamation.

DR. CRAGO read the balance sheet, which showed a balance of £152 16s. 10d. to the credit of the branch.

DR. ELLIS proposed, and Dr. Wm. Chisholm seconded—that the balance sheet be adopted, carried.

The following gentlemen were elected members of the council for the ensuing year:—Drs. Fiaschi, Scot-Skirving, Hankins, Quaife, W. J. O'Reilly, Worrall, Jenkins, Knaggs, Chambers and Crago.

The election of Officers then took place with the following result:—President—G. T. Hankins, Esq., M.R.C.S.; Vice-President—Dr. Scot-Skirving; Hon. Treasurer—Dr. Crago; Hon. Secretary—Dr. Worrall; Auditors—Drs. Ellis and Clubbe.

MEDICAL SOCIETY OF QUEENSLAND.

THE Adjourned Annual Meeting of the above Society was held in the School of Arts, on January 14th, at 8.30 p.m. Present: Drs. W. S. Byrne, (in the chair) Little, Taylor, O'Doherty, Turner, Tilston, Peter Bancroft, Quinnell, E. H. Byrne, Booth and Love.

The minutes of last meeting were read and confirmed.

DR. O'DOHERTY, who was proposed at the last meeting, was balloted for and elected unanimously.

DR. O'DOHERTY stated his intention of proposing that honorary members should be allowed the privileges of ordinary members without going to the vote, upon payment of the annual subscription.

The SECRETARY then read the Treasurer's report, which had been deferred from the last meeting. It showed a credit balance in the Union Bank of £55 1s. 4d., and of £12 5s. in the Government Savings Bank. The report was adopted.

The report of the Bye-Laws Revision Committee was then laid before the meeting, and each Bye-law was discussed seriatim.

The SECRETARY was empowered to have the rules and annual report printed for distribution.

A number of pharmaceutical preparations and instruments were exhibited by Messrs. Elliott Bros.

THE Thirty-ninth General Meeting of the Society was held on the 11th February, at 8.30 p.m., in the School of Arts. Present: Drs. Byrne, Thomson, Shout, Marks, P. Bancroft, Turner, Little, Lyons, Booth, Hardie, Taylor and Love.

The minutes of last meeting were read and confirmed.

DR. LOVE showed a patient with a hydrocele of a hernial sac.

DR. THOMSON proposed, and Dr. Love seconded for membership, F. Paul, M.D. (Brux), M.R.C.S., of Sandgate.

The SECRETARY read for Dr. Hare, an interesting paper on "The true value of Quinine in continued Fevers," which elicited considerable discussion.

The printed copies of the Bye-Laws were distributed to members present.

DR. THOMSON wished it to be recorded in the minutes that in Bye-law 16 the dates to count from date of registration in Queensland, and the word "nominated" to be understood as "proposed and seconded," as this was the intention of the council and general meeting at which the Bye-Laws were passed.

The SECRETARY gave notice that he would move the following at the next general meeting:—

1. That the May meeting be set apart for a Microscopical evening.
2. That a pathological sub-committee be appointed to receive, prepare, and report upon any pathological specimens handed to them by members.
3. That a small sum be annually available from the general fund to meet any expenses incurred by the pathological sub-committee.

DR. BOOTH gave notice that he would move:—

That the council draw up a "Scale of Fees" for the guide of members.

Correspondence with the Managers of the Union and Government Savings' Banks, relative to the change of officers of the society, was read.

It was decided to transfer the society's account from the Union Bank to the Queensland National Bank.

THE Fortieth General Meeting of the Society was held on Tuesday, March 11th, at 8.30 p.m., in the School of Arts. Present: Drs. W. S. Byrne, Connolly, Taylor, Lyons, Hardie, Shout, Owens, Turner, P. Bancroft, Little, E. H. Byrne, Quinnett, K. J. O'Doherty, and Love. Visitor: Dr. Robert Thompson, of Queen Street.

Minutes of last meeting were read and confirmed.

DR. P. BANCROFT showed an anencephalic foetus, also some angular gall-stones removed post-mortem.

DR. LOVE showed a boy with a large keloid growth on the leg following a burn.

DR. PAUL, of Sandgate, was elected a member of the Society.

The HON. SEC. requested that as the Post-office authorities had issued a new post card which was not only much smaller than, but made of very inferior paper to the previous issue, he should be empowered to have notices printed to be filled up for each meeting—Carried.

DR. OWENS made an appeal to the members on behalf of Dr. Moon, of Richmond, London, who had lately been the victim of a vexatious prosecution. Dr. Little replied, giving the details of the prosecution,

whereupon Dr. Owens consented to withdraw his motion.

Correspondence was read from Dr. van Someren, of Townsville, Hon. Secretary of the North Queensland Medical Society, and from Dr. Voss of the Rockhampton Medical Society, requesting copies of the Bye-laws; also from Dr. Robert Thompson, of Queen Street, requesting particulars as to membership; also from L. Bruck, of Sydney, kindly offering 20 volumes for the library; also from Dr. Bancroft, resigning his membership.

A vote of thanks was recorded for Mr. Bruck for his generous offer, which was accepted.

Upon the motion of Dr. O'Doherty, seconded by Dr. Little, the following resolution was carried unanimously, and ordered to be printed in the daily papers:—"That the Medical Society of Queensland wishes to place on record its sincere regret at the death of Dr. Poland, who lost his life in the performance of his duty on the ill-fated "Quetta," and desires hereby to tender its deep sympathy to his bereaved relatives and friends."

DR. HARDIE then read a paper on "Acute Atrophy of the Liver," with notes of six cases which appear elsewhere in our columns.

Upon the motion of the Secretary, seconded by Dr. P. Bancroft, it was decided—(a) To hold a microscopical demonstration at the May meeting. (b) That a pathological sub-committee of 3 members be appointed to receive, prepare and report upon any pathological specimens handed to them by members; Drs. P. Bancroft, Jefferis, Turner and Love, were appointed. (c) That a small sum be available from the general fund to meet any expenses incurred by the pathological sub-committee.

The motion standing in Dr. Booth's name relative to a scale of fees was postponed owing to the absence of "mover."

The LIBRARIAN reported with thanks the receipt of—(a) Mr. Bruck's donation of 20 books to the library. (b) A copy of the proceedings of the last Intercolonial congress from the Secretary. (c) The reports of the sanitary commission lately held in Melbourne.

MEDICAL SOCIETY OF VICTORIA.

THE ordinary meeting of the Medical Society of Victoria was held on April 2nd, at the society's hall, Albert-street, East Melbourne, with the object of determining whether the present influenza epidemic is identical with fog fever, and getting a history of the epidemic in Victoria as a part of its history throughout the world.

DR. GRESSWELL, at the invitation of the society, asked it to co-operate with the Board of Public Health, and with the Victorian branch of the British Medical Association, in drafting a circular to be sent to all medical men in Victoria. The replies are to be permanently preserved by the Board of Public Health.

The medical society cordially approved of the idea, and resolved, on the motion of Drs. Neild and J. P. Ryan, to assist in the manner indicated. A sub-committee, consisting of Dr. Neild, Mr. Girdlestone, and Dr. Syme, was appointed to confer with a committee of three of the Victorian branch of the British Medical Association and Dr. Gresswell as to the drafting of the circular.

DR. M'CREA, the former Government medical officer, was elected an honorary member of the society in recognition of his distinguished services in the past.

NOTICE.

The Editor will feel obliged by any gentleman, who wishes to ventilate any subject of professional or public interest, writing an editorial or leading article on it, which if found on perusal to be consonant with the policy of the paper, will be inserted in an early number.

All communications intended for the Editor should be sent to the 'A. M. Gazette' Office, 35 Castlereagh Street, Sydney.

*** Contributors can have their Papers reprinted and published in Pamphlet form, at Cost Price, if the necessary instructions are given to the Publisher at the same time the contributions are sent in.*

AUSTRALASIAN MEDICAL GAZETTE.

SYDNEY, APRIL 15, 1890.

EDITORIALS.

VACCINATION IN FIJI.

WE have lately received from the Chief Medical Officer of H.M. Government in the Crown Colony of Fiji (the Hon. Bolton Glanville Corney) a copy of an Ordinance with regard to Vaccination which was promulgated about the beginning of last year. It repeals the older Ordinance on the same subject, which was enacted in 1877; and on comparing the new law with the abstract of the old one—which is included by Mr. Bruck in the valuable account of the laws affecting the medical profession in Australasia which precedes his *Medical Directory*—several important amendments appear. But, as the old Ordinance no longer has any force, it will be sufficient to recapitulate briefly the present regulations.

The Chief Medical Officer is made responsible for the administration of the Ordinance: he has to maintain the supply of lymph; to direct Provincial Vaccinators where and when they shall attend for purposes of vaccination; to receive from the latter the record of operations and to file it, and to report before the last day of March in each year to the Governor upon the state and progress of vaccination during the last preceding year. Offences against this Ordinance may be prosecuted on information laid by him, or by any person having general or special authority from him to proceed on his behalf. The executive branch of the official organization consists of Provincial Vaccinators, who may be appointed in any necessary number to each province, and of the existing District Medical Officers. In addition, every duly registered medical practitioner who may vaccinate is required to give certificates of successful operations, and to forward

a copy of the same to the Chief Medical Officer within fourteen days. Production of the certificate given by any one of the three parties mentioned shall be a sufficient defence in proceedings taken under the Ordinance for neglect. The executive thus described is supplemented in the following way: every unvaccinated adult of whatever race, not being an indentured immigrant, is required to present himself for vaccination at a time and place to be publicly notified, under a penalty for neglect of £1 or ten days' hard labour; the master of every indentured immigrant is responsible for the vaccination of his labour within six months of arrival on his estate, or (in order to procure the vaccination of labour already delivered) within six months of the passing of the Ordinance; and lastly, as regards natives, the Provincial Vaccinators are to inform the district-Buli of their intention to begin operations, and the latter is to instruct the chiefs of villages who are to present for vaccination all natives who are above the age of six months and unprotected. The Ordinance applies to all persons on board ships in the waters of the colony.

It will be seen that these provisions are well calculated to bring under inspection nearly all the people, and to secure the vaccination of all who are known to be unprotected. In the former respect the Ordinance seems to have weak points; but the difficulties which the geographical peculiarities of the group throw in the way of perfect administration of this kind are very great, and these are enhanced by paucity of qualified practitioners, or of persons sufficiently well educated to undertake this operation with lymph cultivated for them under skilled supervision. Dr. Corney, however, has for some years carried on with great success at the Suva Hospital the education of chosen natives in some branches of medical knowledge. These attend at the hospital during several years; they act as dressers, get daily clinical instruction from the house-surgeon, read elementary works written in the Fiji language by Dr. Corney, and are frequently subjected to examination. From their ranks, probably, the office of Provincial Vaccinators will be filled; the intention, apparently, being to ensure a proportion of vaccination in those remoter parts of the group which are not under the immediate care of District Medical Officers, as well as the receipt of trustworthy reports of the present state of the people in such parts as to protection. The physical obstacles to medical organization in such a colony as Fiji can scarcely be brought vividly before readers who have no personal knowledge of that group; and the present opportunity may be fitly taken of drawing attention to the important and successful work which Dr. Corney has, nevertheless, carried

on there during many years past. We venture to express a hope that he may some day find leisure to give to the profession in connected form the very large store of observations which he has accumulated with persevering care, touching both the geographical distribution of disease in Polynesia and those especial kinds of illness which are to be met with in Fiji.

INDECENT ADVERTISING.

IN our issue of February we noted with pleasure that the *Shoalhaven Telegraph* had announced its intention of refusing medical advertisements of a non-professional character. The readers of the *Telegraph* will not in future be annoyed by the abominable and indecent advertisements which may be seen generally disfiguring the pages of the Australian daily press. We congratulate them, and hope that the worthy example set by Mr. Maclean may be followed by all other reputable journalists.

In the meantime it may be noted that the evil has assumed such importance, and been productive of such disastrous results in England that the Imperial Parliament have recently placed on the Statute Book an Act dealing specially with the matter.

The Indecent Advertisements Act, passed last session, expressly declares "that any advertisement relating to syphilis, gonorrhœa, nervous debility, or other complaint, or infirmity arising from or relating to sexual intercourse, shall be deemed to be printed or written matter within the meaning of the Act; and provides that the person who gives or delivers to any other person any such indecent picture, or printed or written matter, with the intent that the same should be so affixed, inscribed, delivered, or exhibited, is liable to a penalty not exceeding £5, or, in the discretion of the court, to imprisonment for not more than three months with or without hard labour."

The colonial legislatures have in many instances enacted laws for the public good in advance of the Parliament of Westminster; but in this particular subject, so far as we know, the Imperial Parliament sets them an example which may well be followed.

The medical advertisements in the colonial press scar and disfigure it to the disgust of all right-minded people.

Medical men know, perhaps, more of the special evils wrought by these indecent announcements than the general public; so much so that it is entirely unnecessary to dwell in these pages on the desirability of an act to suppress them.

Members of our profession may do much privately and individually to influence public opinion and prepare the way for legislative action, similar to that now obtaining in the United Kingdom.*

CLINICAL ASSISTANTS AT THE ADELAIDE AND PARKSIDE ASYLUMS.

WE are pleased to see that the numerous and important general duties of his office as Chief Secretary and Premier of South Australia have not prevented Dr. Cockburn from still giving the benefit of his professional knowledge to that colony, as is shown by the subjoined correspondence. On September 23 last he wrote to the Chancellor of the Adelaide University, making the following valuable proposition:—

"It has been suggested that the valuable field for the study of mental pathology afforded by the Adelaide and Parkside Asylums might be rendered further available for advanced students and recent graduates in medicine at the University of Adelaide. An arrangement might be made similar to that in relation to the Adelaide Hospital, whereby one or more recent graduates might hold office as resident medical physicians, under whom students attending asylum practice might be organized as medical clerks. Should the council be of opinion that it is desirable to take steps in this direction there would be little difficulty in arriving at a scheme mutually advantageous to all concerned." On October 2 the registrar of the University wrote to the Chief Secretary as follows:—"I am directed to express to you the cordial thanks of my council for your very valuable suggestion, and to inform you that they will gladly avail themselves of it. Our council have referred your letter to the faculty of medicine with instructions to report thereon, and to devise a practical scheme for carrying your suggestion into effect." On October 29 the registrar again wrote:—"I have to inform you that my council at its meeting on Friday last received the following report from the faculty of medicine on the subject of your letter of September 23:—"The faculty of medicine are of opinion that it is desirable to adopt the suggestions of the Hon. the Chief Secretary, and in order to give them effect the faculty recommend—1. That the appointment suggested by the Chief Secretary should be held by duly qualified medical men, who would probably be young graduates of the University. 2. That the appointment should be held for not less than six months. 3. That the salary of such appointment should be at the rate of £100 a year with board and lodging. 4. That the officer appointed should be called the clinical assistant. The faculty of medicine in fixing the honorarium at the rate of £100 a year thought it desirable to suggest a rather higher salary than that paid for similar appointments at the hospital, as the asylums do not possess the same attractions for medical men." After some discussion my council adopted the report." The Government have agreed to place £100 on the Estimates to meet the requirements of the salary of one officer, and the Chief Secretary has asked the colonial surgeon to report as to whether an assistant will be required for each asylum or whether one would be preferable. It is expected that the new arrangement will come into force on July 1 next.

* By journals to hand since the above was written we learn that the punitive provisions of the Act are being successfully enforced.

THE NEXT AUSTRALASIAN MEDICAL CONGRESS.

At the Special Meeting of the Australasian Medical Congress held in Melbourne on January 12, 1889, it was determined that the next session should "be held in Sydney in the year 1892 or at such earlier period as the Medical Societies of New South Wales may determine."

It was tacitly understood that the meeting was to take place during the cool season of the year, and that the time should be about September or October, 1891, we therefore think it our duty to remind the medical societies that time is passing, and that it is not too early for their taking the subject into consideration, determining the date of the next Congress, and making the necessary preliminary arrangements. Before this time it has hardly been possible to do this, owing to the absence of the Hon. Dr. MacLaurin, the President-elect, in Europe, but now that he has returned to Australia this cause for delay is passed.

MEDICAL AFFAIRS IN SOUTH AUSTRALIA.

THOUGH upwards of three months have elapsed since the passage of the amending Medical Act in South Australia, no Medical Board has yet been appointed to take the place of the old one, the members of which so unselfishly resigned on August 26, 1889, from conscientious objections to the liability which, by a decision of the Supreme Court, they were under to register diplomas that they considered were of an untrustworthy character. As a consequence of there having been no Medical Board for seven months in that colony no list of medical practitioners has been published for this year, and no new arrivals have been registered. The Medical Superintendent and four other resident medical officers of the Adelaide Hospital being unregistered at the present time. These gentlemen are, of course, fully qualified, but the anomaly remains that the metropolitan hospital has five unregistered medical practitioners for its resident staff, which, we are sure, must be in contravention of the constitution under which it has been established.

The continued neglect of such a vital matter as the appointment of a Board for the carrying out of the Acts regulating the practice of medicine is not creditable to the Government of South Australia, and is the less so when the Premier is a member of the profession. We trust that directly the general election now pending is over—which may be pleaded as an excuse for delay—that this important subject will receive due attention.

A CASE OF SNAKE-BITE.

A MAN named William Brown was bitten on the left hand by a snake, near Adelong, a country district of New South Wales, during the second week of March. He made a good recovery, the only treatment adopted being his own idea of keeping the bitten limb immersed in running water for many hours. He also kept awake during the thirty-six hours following the bite, when, it is stated as a notable circumstance, he "was getting very sleepy." We think it would have been more noteworthy if after the lapse of so long a period without sleep, spent in the greatest mental anxiety and with very considerable bodily exertion, he were not "sleepy."

We have no hesitation in saying that we are of opinion that the treatment he underwent had no effect in bringing about his recovery, except so far as it occupied his mind, and by giving him confidence prevented his being overcome by the fear which takes possession of all persons suffering from snake-bite. We think that the amount of snake poison injected in this instance was not sufficient to produce a fatal result, and it was this, and not the "treatment," which averted a fatal termination. With the discovery of Dr. Mueller of the effect of the hypodermic injection of strychnia in snake-bite, and after the constantly reported cases of its success, we think it does not admit of discussion that a case of snake-poisoning not treated by this method has not had everything done for its remedy which might have been.

LETTERS TO THE EDITOR.

INDECENT ADVERTISEMENTS.

(To the Editor of the A. M. Gazette).

DEAR SIR,—With reference to the first Editorial in the A. M. Gazette for March, 1890, I may state that a correspondence almost exactly similar to the one there quoted occurred in the case of a patient lately under my care. In this instance the patient was an anæmic single young lady suffering from amenorrhœa, whose father, unknown to herself, wrote to "Dr." Richards and received a reply almost precisely the same as the one you have published. The gentleman felt naturally indignant at receiving such a reply, and shewed me the letter, but from feelings of shame was averse to me forwarding it to you for exposure. That many thousands of persons do consult advertising "Doctors" is proved by the enormous sums spent by these men on advertisements. Every medical man practising in the Colony must have had dozens of patients who have fallen into the hands of these impostors, been robbed of their savings, and left worse off than before; or, perhaps, some more fortunate, by appealing accidentally to legitimate practitioners, have been restored to health and self-respect by simple and infinitely less expensive methods.

As there seems no probability of the Colonial Legislature passing a reasonable law dealing with the matter, could not this subject be approached indirectly by an Act similar to that passed by the Imperial Parliament last session—i.e., "The Indecent Advertisements Act"? This Act, among other things, expressly declares that any advertisement relating to syphilis, gonorrhoea, nervous debility, or other complaint, arising from or relating to sexual intercourse, shall be deemed to be printed or written matter within the meaning of the Act.

There is an excellent article on this subject in the *British Medical Journal* for January 4, at p. 27; and in the *Chemist and Druggist* for the same month there is a case of successful prosecution of a chemist for advertising in a shop window a cure for "Nervous Debility."

Surely it is reasonable to suppose that if these advertisements are *indecent* in England they must be indecent in the Australian Colonies! and, if so, could not any member of our Legislature be induced to bring in a bill to attack this Hydra-headed monster from this standpoint?

In Great Britain the British Medical Association has a Parliamentary Bills Committee, by means of which the whole weight of British medical opinion can be brought to bear on the provisions of any Act brought under its notice. Would it be possible to form some similar organization in Australia, not only for the benefit of the profession itself, but also for the protection of an easily-gulled public? Medical men alone have any idea what mischief is done by these advertisements, and to their notice is brought but a fractional part of this wide-spreading social disease; and, therefore, it seems but right that they should bestir themselves in the matter if there be any hope of ultimate success.

"The History of an American University," in the *British Medical Journal*, for January 18, p. 140, exposes another method of imposing upon the public, with which nothing but a Medical Board, equipped with full powers, can cope. For getting at the root of these matters, however, we must look to the public spirit of the Australian people, who cannot long continue to tolerate a scandal so frequently exposed by the medical and lay press.

Trusting that you, Sir, will continue to combat this plague, both from the editorial chair and from your place in the Legislative Council of the Colony,

I am, dear Sir,

Yours, &c.,

MEMBER BRIT. MED. ASSOCIATION
(UNATTACHED).

PUZZLING CASES.

(To the Editor of A.M. Gazette.)

SIR.—It is frequently a matter of difficulty to distinguish between serious and non-serious cases applying for admission to our hospitals. A man is brought up in charge of a policeman and all his symptoms point to an overdose of alcohol, and frequently this acts as a mask in obscuring graver affections. The surgeon sees only that he is drunk, and being unwilling to occupy his beds with such cases, which do not come under the head of charity and are a source of annoyance to the other patients, allows the policeman to remove him to the cells. It chances that the man dies, and at the inquest the medical officer is censured

because the *post mortem* revealed a clot of blood in the brain. He may prove conclusively that the effusion of blood took place subsequent to his examination, but the public think that appearances are against him. I knew a case of this kind to happen at a large hospital and the coroner's jury to bring in an unfavourable verdict, which was totally opposed to all medical literature on the subject. The medical officers had done their duty in refusing to admit a drunken man, who was afterwards attacked by a fit of apoplexy, which might have happened to anyone else. Certainly the hospital committee exonerated them from all blame, but the verdict was an unpleasant reflection on their reputations.

The above case is an example of what may happen to any medical man. There are others, however, concerning which his reputation is placed in danger. Only a short time ago a policeman brought a man to this hospital who was suffering from the effects of alcohol; he was very excited and had a little difficulty in breathing. I put my fingers on the radial artery but could feel no pulsation and thought it rather strange that the man could keep up such excitement when the circulation was so feeble. I took him in, and in the quiet of the ward listened to his heart sounds, when I heard a loud aneurismal bruit over the arch of the aorta. The bruit disappeared in a few days, when he was calmed down under bromide of potassium, but of course the disease remained. If the heart had not been excited I might never have detected the aneurism by auscultation.

I recollect another case some years ago that completely baffled me. A man applied for admission to the Sydney Hospital with symptoms about the abdomen greatly resembling dyspepsia. I took him in at the time but did not keep him long in the institution. He applied again, but failing to detect any disease I was going to refuse him admission when his protestations appealed to my pity, and I took him in "for a short time," but could not believe that the abdominal symptoms proceeded from anything worse than dyspepsia. One morning shortly after this the nurse came hurriedly to tell me that the man was dying. I went to the ward and found him dead. Subsequently I made a *post mortem* and discovered that a large abdominal aneurism had burst into the left pleural cavity. Cases of this kind and many others that I could mention teach us to exercise care, and show us that the science of medicine is of such a nature that we cannot be too dogmatic in coming to hasty conclusions.

I think all hospitals should have an observation ward into which cases that present doubtful symptoms could be placed for further examination. This would greatly relieve the minds of the medical officers and at the same time prevent a charitable institution from being disgraced by unfavourable verdicts.

I am, etc.,

JOHN ERNEST MOFFITT,
Resident Surgeon.

Creswick Hospital, Victoria,
4th February, 1890.

WE have received from the agents, Messrs. Shadler, Koeniger & Co., whose advertisement appears in another place, some samples of Medicinal Tokay Wine from the celebrated vineyard of Ern. Stein, near Tokay, in Hungary. It is sweet and full-bodied, and has a delicious aroma, and should be of value as a tonic for convalescents. We recommend our readers to send for sample bottles and judge for themselves.

THE MONTH.

NEW SOUTH WALES.

THE Grenfell Hospital committee have accepted a tender at £1,670 for the erection of a new hospital.

A COTTAGE hospital has been opened at Hillgrove, about 20 miles from Armidale.

THE newly-established Nepean Cottage Hospital at Penrith was opened on the 9th April.

THE Moruya Cottage Hospital has just been completed; provision has been made for 10 beds, 6 for male and 4 for female patients.

CHARLES PEARSON HIGGS, an unregistered practitioner, who has been practising in Dungog for the past 27 years, has been committed for trial, charged with causing the death of an old man named Maurer, whom he attended, and who was suffering from a broken leg, by criminal neglect and unskilful treatment.

DR. C. F. COXWELL, of Orange, has left for England by the R.M.S. "Britannia."

DR. J. F. DECK, of Ashfield, has returned to the colony from his trip to England by the R.M. steamer "Austral."

DR. W. FINLAY, late of Bathurst, has commenced practice at Young.

DR. F. W. KANE has succeeded to the practice of Dr. G. Watt, at Cobar.

DR. H. N. MACLAURIN has returned to Sydney from his trip to England by the R.M. steamer "Britannia."

DR. J. N. E. MACLENNAN has commenced practice at Murrumburrah, 230 miles S. of Sydney.

DR. A. E. MILLS, late resident medical officer at the Prince Alfred Hospital, has been appointed demonstrator of anatomy at the Sydney University.

DR. G. L. MULLINS, of Waverley, has been granted the M.D. degree (a.e.g.) of the Sydney University.

MR. HENRY RICKARDS, M.R.C.S. Eng., et L.S.A. Lond. 1836, died at Hunter's Hill, near Sydney, on the 26th March, at the age of 76 years.

DR. J. F. SOUTER has settled at Lake Cudgellico, a postal township 465 miles W. of Sydney.

DR. F. C. STEVENSON, who has been practising at Scone for the last four years, was, on March 19, the occasion of his leaving the district for Longford, in Tasmania, presented by his many friends and admirers in the Scone district with a beautiful silver tea and coffee service and a handsome spirit stand, the value of the whole being about £50.

DR. B. R. TRENDALL, late of Helensburgh, has been appointed one of the two medical officers of the United Friendly Societies in Parramatta.

DR. T. F. WADE, of the Sydney Hospital, has been elected medical officer of the newly-established hospital at Barraba, 339 miles N. of Sydney.

NEW ZEALAND.

THE influenza epidemic, which was prevalent in Europe recently, has broken out in New Zealand, but all the cases so far are of a very mild character.

DR. JOHN GUNN, late of Dundee (Scotland), has settled at Lyttelton, the seaport of Christchurch.

DR. J. H. HONEYMAN, of Auckland, has left for England by the R.M.S. "Britannia."

DR. A. F. J. MICKLE, of Christchurch, has been awarded £1,000 damages in an action for slander brought against Captain Everest, who had stated that plaintiff had been guilty of improprieties with Mrs. Everest.

DR. J. P. MILLINGTON, late of Wolverhampton (Eng.), has commenced practice at Greymouth, on the West Coast, 33 miles N. of Hokitika.

DR. W. J. MULLIN, a graduate of the University of New Zealand, has settled at Reefton, 53 miles S. of Westport.

DR. J. SOMERVILLE has commenced practice at Mataura, 107 miles S.W. of Dunedin.

DR. JAMES TILBY, late of Pukekohe (Prov. Auckland), has gone to Rarotonga, in the South Sea, to settle there.

QUEENSLAND.

DR. G. S. L'ESTRANGE, of Roma, has been appointed a Justice of the Peace.

DR. J. A. FORREST has settled at Mount Morgan.

DR. ROBERT THOMPSON has commenced practice in Brisbane as a specialist for diseases of the eye.

SOUTH AUSTRALIA.

THE death is announced of Mr. Henry Howard Bovill, M.R.C.S. Eng. et L.R.C.P. Lond. 1880, who arrived in this colony in 1885, and after practising at Mount Barker for some years, he was, early in 1888, appointed acting Government Medical Officer for the Northern Territory during the absence on leave of Dr. P. M. Wood. On the return of Dr. Wood, about the middle of last year, Dr. Bovill left Port Darwin for London.

THE residents of Mallala are anxious to obtain the services of a resident medical practitioner; Mallala is the centre of a grazing and agricultural district 37 miles north of Adelaide. The population is about 320, and of the district upwards of 1000.

DR. E. W. MORRIS, late of Reading (Eng.), has settled at Port Adelaide.

TASMANIA.

A number of cases of influenza have occurred at Hobart. The malady is of a mild character.

DR. S. M. ROOME, late of Richmond, has left for Europe by the M.M. steamer "Yarra."

DR. F. C. STEVENSON, late of Scone (N.S.W.), has commenced practice at Longford, 18 miles south of Launceston.

VICTORIA.

THE provisions of the Imperial Medical Act are to be applied to Victoria. This is the first step towards having medical degrees which have been conferred by the Melbourne University recognised in Great Britain. It will now be for the Melbourne University authorities to apply to the General Medical Council of Great Britain to have the medical degrees conferred by that institution recognised in the old country. When they are so recognised medical students who have passed through the Melbourne University and obtained their degrees, will, on proceeding to England, be registered as practitioners in Great Britain, and will be permitted to practise there as such without undergoing any further examinations.

THE Chief Secretary has received a report from the Police Department in reference to certain rumours that cases of infanticide are of frequent occurrence in the city and suburbs, and that many such cases, along with illegal operations, which are carried on in a wholesale manner, escape detection. The report tabulates all cases which have recently come before the law courts, also relating to circumstances tending to show that there are many others never heard of. The report also mentions the names of several medical men in the metropolis and suburbs who have the reputation of being concerned in numerous cases of malpractice. Ample proof is given of the necessity of legislation for the suppression of such offences. It is probable that the subject will be brought forward in Parliament.

THE influenza epidemic has reached Victoria, many hundred cases having occurred in Melbourne and suburbs. Dr. Gresswell saw a number of persons affected, and he has no doubt in his mind that the complaint is that which has ravaged Europe. With a few exceptions the cases were of a mild character.

DURING the week ended the 15th March, 249 cases of typhoid were reported throughout the colony, of which 25 were fatal. The numbers include 149 in the metropolitan area. During the same period there were 82 cases of diphtheria and 17 deaths, including 34 cases with 8 deaths in the metropolitan area.

DURING the week ended 22nd March 96 cases of diphtheria, with 25 deaths, were reported throughout the colony; typhoid, 218 cases, with 11 deaths, being an increase in the diphtheria cases, with a decrease in the typhoid cases on the preceding week.

AT a recent meeting of the Women's Hospital, Melbourne, Mrs. Moloney moved—

"That no person shall be eligible for election as a resident medical officer unless, in addition to the requirements of the medical practitioner's statute of 1865, he be possessed of a degree in medicine and surgery from the University of Melbourne."

Mrs. Maloney stated that at a late election a licentiate of another university was accepted in preference to a local M.D., and she thought that a locally trained officer, if his qualifications were satisfactory, should have the preference. Mr. Templeton seconded the motion, which was lost by 10 votes to 5.

MR. THOMAS JAMES BARR, L. et L. Mid., R.C.P. et R.C.S. Edin., 1886; L.F.P.S. Glas., 1886, died on April 2nd at Hawthorn, near Melbourne, from heart disease, at the age of 44 years; the deceased gentleman arrived in the colony three years ago, when he commenced practice at Castlemaine, and about twelve months ago removed to Hawthorn. He leaves a widow and two children.

MR. MATTHEW BRISBANE, L. et L. Mid. R.C.S., Edin., 1853, of St. Arnaud, an old colonist of 28 years' standing, is dead; the deceased gentleman was a justice of the peace, also public vaccinator at St. Arnaud, and health officer for the shire of Kara Kara.

THE death is announced of Mr. Robert Knaggs, M.R.C.S. Eng., et L.A.H., Dubl. 1830, one of the oldest residents of Victoria, who died at his residence, West Melbourne, on 23rd March, at the ripe age of 91 years; the deceased gentleman was a justice of the peace, and formerly a member of the Medical Board of Victoria.

WE regret to have to record the death of Mr. Eyre Henry Charles Massy, L. et L. Mid., R.C.P. et R.C.S., Edin. 1870, a native of Stagdale, Co. Limerick, and a colonist of 20 years' standing, who died at Daylesford, on 15th March, aged 42 years; the deceased gentleman, soon after his arrival in Victoria, was appointed House

Surgeon at St. Arnaud Hospital, and afterwards he obtained a similar position to the Daylesford Hospital, which he resigned some years ago in order to devote all his time to his private practice.

MR. CHARLES YALDWIN SHUTER, M.B. Durh. 1883; M.R.C.S. Eng. 1883; L.S.A. Lond. 1883; M.B. (a.e.g.) Melb. 1886, late of Kensington, near Melbourne, died at the residence of his father, Mr. Charles Shuter, P.M., at Malvern, on 7th April, aged 30 years. The deceased gentleman was formerly House Physician at Guy's Hospital, London, and House Surgeon at St. Andrew's Hospital, Northampton, and also Resident Medical Officer at the Northampton County Lunatic Asylum. On his return to the colony in 1885 he was appointed Resident Medical Officer at the Creswick Hospital, which appointment he relinquished in 1887, when he settled at Kensington, a suburb of Melbourne.

MR. JOHN SUTHERLAND, L. et L. Mid., R.C.P. et R.C.S. Edin., L.F.P.S. Glas. 1885, formerly house surgeon of the Alfred Hospital, Melbourne, and late of the Hospital at Broken Hill (N.S.W.), died suddenly of heart disease on 22nd March, at Prince's Hill, North Carlton, near Melbourne, at the age of 28 years.

DR. JOHN E. BARRETT, of South Melbourne, has left for England as a member of the Australian cricketing team.

DR. H. K. BEAN, late of Heidelberg, has left for England.

DR. W. H. CUTTS, junr., of Oakleigh, met with an accident on March 24. He was riding out after night-fall to visit a patient when his horse fell over a large heap of spalls, which had been left at the roadside to be broken into metal. Dr. Cutts was thrown clear of the heap; however, he had one finger broken, his knee severely bruised, and his face cut in one or two places.

MR. JAS. DUNCAN, a new arrival, has settled at Williamstown, and Dr. J. M. M. Muir at Ballarat.

DR. J. ELLISON has removed from Caulfield to Numurkah, 133 miles N. of Melbourne.

DR. ABBATOON GABRIEL, late of Calcutta, has commenced practice at Dunolly, 125 miles N.W. of Melbourne.

DR. C. E. GRAY, late of Albert Park, has returned from Europe and resumed practice at Auburn, a suburb of Melbourne.

THE appointment of Dr. Dan Astley Gresswell as Medical Inspector for the purposes of the Public Health Acts, has been gazetted.

DR. T. J. M. KENNEDY, of the Melbourne Hospital, has been elected Resident Surgeon of the Geelong Infirmary, in the place of Dr. Marwood, who recently resigned; there were nineteen applicants for the vacant position.

DR. R. J. LEEPER, late of Dublin, has settled at Tarnagulla, 140 miles N.W. of Melbourne.

DR. W. C. LITTLE has commenced practice at Wer-racknabeal, 262 miles N.W. of Melbourne.

DR. G. R. MOORE has settled at Yarrowonga, 166 miles N.E. of Melbourne.

WESTERN AUSTRALIA.

DR. J. H. LOVEGROVE, formerly of Derby, has been appointed Acting Colonial Surgeon during the absence on leave of Dr. A. R. Waylen. Dr. Lovegrove has also been appointed President of the Medical Board, Superintendent of Vaccination, Public Vaccinator Perth District, and Member of the Central Board of Health.

DR. GEO. BOYES has resigned his appointment as Resident Medical Officer at Greenough.

PROCEEDINGS OF THE COLONIAL MEDICAL BOARDS.

The following gentlemen, having presented their diplomas, have been duly registered as legally qualified Medical Practitioners by the respective Boards:—

NEW SOUTH WALES.

Dowdell, Charles Seymour, L.R.C.P. Lond. 1888; M.R.C.S. Eng. 1888.
 Peare, Humphry Robert Henry, L. & L. Mid. K.Q.C.P. Irel. 1887.
 Scanlon, Charles Edward Foucart, M.B. & M.S. Univ. Glas. 1886.
 Steel, John, M.B. & Ch. M. Univ. Edin. 1883; L.R.C.P. & R.C.S. Edin. 1882.
 Patton, Alexander Stoney, M.B. & Ch. Univ. Dub. 1885.
 Birchall, Thomas Barron, M.B. & Ch. M. Univ. Glas. 1879.

For Additional Registration:—

O'Connor, Maurice John, M.K.Q.C.P. Irel. 1884; L. Mid. K.Q.C.P. Irel. 1877.

NEW ZEALAND.

Gunn, John, M.B. & Ch. M. Glas. 1876.
 Millington, John Perrett, L.S.A. of Lond. 1887.
 Mullin, William John, M.B. Univ. of N.Z. 1890.

QUEENSLAND.

Ryan, Jeremiah Berohan, L.R.O.S. Irel. 1886; L. & L. Mid. K.Q.C.P. Irel. 1886.

TASMANIA.

Hood, James Crockett, M.D. 1883; Ch. M. 1884; Roy. Univ. Irel.

VICTORIA.

Webb, James Ramsay, M.B. Melb. 1889.
 Lewers, Alexander, M.R.C.S. Eng. 1889; L.R.C.P. Lond. 1889; L. & L. Mid. R.C.P. & R.C.S. Edin. 1889, L.F.P.S. Glas. 1889.
 Bracewell, Walter Hansford, M.B. Melb. 1889.
 Gabriel, Arratoon, L. & L. Mid. R.C.P. & R.C.S. Edin. 1875.
 Bird, Richard Kingston, L. & L. Mid. R.C.P. & R.C.S. Edin. 1889; L.F.P.S. Glas. 1889.
 Leeper, Richard John, L.R.C.S. Irel. 1885; L.A.H. Dub. 1887.
 Hare, Walter Thomas, M.B. Melb. 1889.
 Cheetham, Ernest James, L. & L. Mid. R.C.P. & R.C.S. Edin. 1889; L.F.P.S. Glas. 1889.
 Duncan, James, L. & L. Mid. R.C.P. & R.C.S. Edin. 1889; L.F.P.S. Glas. 1889.
 Rigby, George Owen, M.B. Melb. 1889.
 Muir, James Miller Mackay, M.B. & Ch. M. Glas. 1889.
 Greenwell, Dan A.ley, M.R.C.S. Eng. 1881, D.P.H. Camb. 1884.
 Wallace, Samuel Lane, L. & L. Mid. R.C.P. & R.C.S. Edin. 1871.
 Taylor, Inglis, L. & F.R.C.S. Edin. 1889.
 Steele, John, M.B. & Ch. M. Edin. 1881, L.R.C.P. & R.C.S. Edin. 1882.

Additional qualifications registered:—

Damman, George W., Ch. B. Melb. 1889.
 Thomson, James S., M.R.C.S. Eng. 1889.
 Murphy, Thomas, Ch. B. Melb. 1888.

MEDICAL APPOINTMENTS.

Barber, Alexander, L.R.C.S. Irel., to be Government Medical Officer and Vaccinator for the district of Hillgrove, N.S.W.
 Christie, William Walls, M.D. & Ch.M. Glas., to be Public Vaccinator for the districts of Woodville and Danvirke, N.Z.
 Ellison, John, M.D. & Ch.M. Roy. Univ. Irel., to be Health Officer for Shire of Numurkah, Vic.
 Guthrie, Emil, M.B. Melb., appointed Resident Surgeon of the Melbourne Eye and Ear Hospital, in the place of Dr. W. J. Craig.
 Hynes, Timothy Augustine, M.B. & Ch.M. Edin., to be Public Vaccinator at Adelaide.
 Jermyn, Frederick David, M.B. & Ch.B. Melb., to be Public Vaccinator at Kororoi, Vic.
 Leeper, Richard John, L.R.C.S. Irel., to be Health Officer and Public Vaccinator at Tarnagulla, Vic. vice Dr. G. B. D. MacDonald, resigned.
 Macandrew, Herbert, M.B. & Ch.M. Edin., to be a Public Vaccinator for the district of Hokitika, N.Z.
 Moore, George Richmond, M.R.C.S. Eng., to be Health Officer for Shire of Yarrowonga, Vic.
 Morris, Edward Walter, M.R.C.S. Eng., to be Public Vaccinator at Port Adelaide, S.A.
 Morrison, Reginald Herbert, M.B. & Ch.M. Edin., to be Health Officer for Shire of Oakleigh, Vic.

Potts, Walter Alfred Beevor, M.R.C.S. Eng., to be Public Vaccinator at Serviceton, Vic.
 Smith, Robert, L.R.C.S. Edin., to be Health Officer for Avenel, Vic.
 Somerville, John, M.B. & Ch.M. Edin., to be Public Vaccinator for the district of Matamora, N.Z.
 Wolfenden, James Jackson, L.R.C.S. Irel., L.K.Q.C.P. Irel., to be Public Vaccinator at St. Arnaud, Vic.

BIRTHS, MARRIAGES, AND DEATHS.

* * * The charge for inserting announcements of Births, Marriages, and Deaths is 2s. 6d., which should be forwarded in stamps with the announcement.

BIRTHS.

BOYD.—On the 22nd March, at Sandhurst, Vic., the wife of Dr. Hugh Boyd, of a daughter.
 CLENDINNEN.—On the 1st April, at Hawksburn (Melbourne), the wife of F. J. Clendinnen, M.D., of a daughter.
 FLORANCE.—On the 5th March, at Bungendore, New South Wales, the wife of Egbert Florance, M.D., of a son.
 GARDE.—On March 14th, at The Hospital House, Maryborough, Queensland, the wife of H. O. Garde, F.R.C.S., of a son.
 HEWER.—On the 17th February, at Aramac, Qn., the wife of Dr. H. J. Hower, of a daughter.
 JACK.—On the 1st March, at Stawell, Vic., the wife of R. Nelson Jack, L.R.C.P. and L.R.C.S.R., of a daughter.
 MATHESON.—March 2, 1890, at Cowper-street, Waverley, (Sydney), the wife of M. Matheson, M.D., of a daughter.
 NICKOLL.—February 22, at Mudgee, N.S.W., the wife of Dr. Harvey Nickoll, of a son.
 SCHLESINGER.—On the 9th March, at Windsor (Melbourne), the wife of Dr. R. E. Schlesinger, of a son.
 SCHWARZBACH.—March 17, at Sydney, the wife of Dr. B. Schwarzbach, of a son.
 SUTTON.—On the 22nd March, at Beenleigh, Qn., the wife of Dr. Alfred Sutton, of a son.
 TRAVERS.—On the 4th March, at East Prahran (Melbourne), the wife of Dr. Travers, of a son.

MARRIAGES.

ARTHUR-BRUCE.—March 19, at Coolangatta, Shoalhaven, N.S.W., by the father of the bride, Richard Arthur, M.A., M.B., to Jessie Sinclair, daughter of the Rev. D. Bruce, formerly of Auckland, New Zealand.
 COLE-TELFORD.—On the 21st March, at North Brighton, Vic., Francis Cole, M.B., Ch.B., M.R.C.S. Eng., to Janet Tweeddale, youngest daughter of the late James Campbell Telford, M.D.
 COTTEE-MORGAN.—February 26, at St. Jude's, Bowral, N.S.W., by the Rev. J. W. Debenham, M.A., Edgar Alfred, eldest son of W. A. Cottee, Esq., of "Horsley," Burwood, to Annie Dyne, eldest daughter of Dr. Cooby Morgan, of Newcastle, N.S.W.
 M NEILL-MURDOCH.—February 27, at the Presbyterian Church, Ashfield, John P. McNeill, B.A., M.D., of Burwood, to Frances Henderson Murdoch, niece and adopted daughter of Henry Murdoch, "Rostrevor," Albert-parade Ashfield, (Sydney).
 NASH-ROUSE.—March 12, at St. Peter's Church, Hamilton, Andrew William Nash, M.B.C.M., Ed., to Maud Frances, second daughter of Henry Rouse, Hamilton, Newcastle, N.S. Wales.
 PHILLIPS-JOHNSTON.—On the 8th March, at St. John's Cathedral, Dr. G. Gordon O. Phillips, of Heidelberg, Victoria, to Blanche, daughter of the late Boyd A. Johnston, of Greenock, Scotland.
 NISBET-BOOTH.—On the 8th March, at the Parish Church, Toowong (Brisbane), Walter B. Nisbet, M.B., of Townsville, to Mildred Janet, daughter of Richard Booth, of Northamptonshire, England.
 WOOD-ROBERTS.—On January 28, 1890, at St. Luke's, Redcliffe Square, South Kensington, by the Rev. Herbert Maitland, cousin of the bridegroom, assisted by the Rev. H. H. Bartrum and the Rev. W. Fraser-Hancock, Vicar, Percy Moore Wood, M.R.C.S., L.R.C.P. London, 1st Government Medical Officer at Port Darwin, South Australia, son of the late Charles William Wood, Q.C., to Janet Sophia, younger daughter of Richard Willett Roberts, of 34 Redcliffe Square and Gray's Inn.

New Zealand Calf Lymph, 2s. 6d. a tube, well filled. L. Bruck, Sydney.

MR. BRUCK begs to call the attention of the profession to his revised price list of Surgical Instruments and Appliances in this issue.

A FIFTH YEAR Medical Student is willing to assist a Medical man in return for board and lodging, and a small remuneration.—Address, "X," *Medical Gazette*, Castlereagh Street.

REPORTED MORTALITY FOR THE MONTH OF FEBRUARY, 1890.

Cities and Districts.	Population.	Births Registered.	Deaths Registered.	Deaths under Five Years.	Number of Deaths from									
					Measles.	Scarlet Fever.	Croup and Diphtheria.	Whooping Cough.	Typhoid Fever.	Dysentery and Diarrhoea.	Phthisis.	Heart Disease.	Cancer.	Child-bearing.
N. S. WALES.														
Sydney	132,846	...	...	...	...	...	...	...	...	...	...	...	...	...
Suburbs	215,849	..	..	..	..	..	..	..	..	..	..	..	..	..
NEW ZEALAND.														
Auckland	33,307	68	28	11	...	...	...	...	2	3	4	5	1	..
Christchurch	17,116	19	12	6	...	...	...	...	..	2	..	2	1	..
Dunedin	24,168	48	21	8	...	...	...	...	..	2	1	3	..	..
Wellington	31,028	75	30	12	..	...	1	...	3	6	2	3	3	..
QUEENSLAND.														
Brisbane	51,689	193	87	44	} ...	2	8	1	4	11	12	2	2	3
Suburbs	21,960	180	30	21										
SOUTH AUSTRALIA	319,166	...	...	...	...	...	...	...	...	...	...	...	...	...
Adelaide	44,581	...	...	...	...	...	...	...	...	...	...	...	...	...
TASMANIA.														
Hobart	35,686	...	...	...	...	...	...	...	...	...	...	...	...	...
Launceston	21,966	...	...	...	...	...	...	...	...	...	...	...	...	...
Country Districts	94,035	...	...	...	...	...	...	...	..	..	...	...	...	...
VICTORIA.														
Melbourne	75,400	...	...	} ...	...	...	...	...	...	...	...	...	...	...
Suburbs	362,385	...	...		...	...	...	...	...	...	...	...	...	...

METEOROLOGICAL OBSERVATIONS FOR FEBRUARY, 1890.

STATIONS.	THERMOMETER.					Mean Height of Barometer.	RAIN.		Mean Humidity.	Prevailing Wind.
	Maximum Sun.	Maximum Shade.	Mean Shade.	Minimum Shade.			Depth.	Days.		
							Inches			
Adelaide—Lat. 34° 55' 33" S. ; Long. 138° 36' E. ....	...	...	...	...	...	...	...	...	...	...
Auckland—Lat. 36° 50' 1" S. ; Long. 174° 49' 2" E.	147	82	68.3	52	...	...	0.070	3	61	...
Brisbane—Lat. 27° 28' 3" S. ; Long. 155° 16' 15" E.	150.7	90.8	74.0	63.7	29.874	...	7.444	23	82	...
Christchurch—Lat. 43° 32' 16" S. ; Long. 172° 38' 59" E.	161.8	94.8	62.5	37.4	...	...	0.077	5	62	...
Dunedin—Lat. 45° 52' 11" S. ; Long. 170° 31' 11" E.	134	81	60.4	44	...	...	0.614	5	71	...
Hobart—Lat. 42° 53' 32" S. ; Long. 147° 22' 20" E. ....	...	...	...	...	...	...	...	...	...	...
Launceston—Lat. 41° 30' S. ; Long. 147° 14' E. ....	...	...	...	...	...	...	...	...	...	...
Melbourne—Lat. 37° 49' 54" S. ; Long. 144° 58' 42" E. ....	...	...	...	...	...	...	...	...	...	...
Sydney—Lat. 33° 51' 41" S. ; Long. 151° 11' 49" E. ....	...	...	...	...	...	...	...	...	...	...
Wellington—Lat. 41° 16' 25" S. ; Long. 174° 47' 25" E.	189	82	63.2	43	...	...	0.240	5	67	...

AUSTRALASIAN MEDICAL GAZETTE.

ORIGINAL ARTICLES.

ACUTE ATROPHY OF THE LIVER IN PREGNANCY.

READ BEFORE THE MEDICAL SOCIETY OF QUEENSLAND, ON MARCH 11, 1890.

BY DAVID HARDIE, M.D., HON. PHYSICIAN
LADY BOWEN LYING-IN HOSPITAL, AND
HOSPITAL FOR SICK CHILDREN, BRISBANE.

ABOUT two years ago I saw my first case of acute atrophy of the liver, but did not recognize its nature till after death. When I say first case, I should mention that about four years ago in the old country I attended for a short time, a young medical man who was intensely jaundiced, and was told afterwards that he died from this terrible disease. During the last eight months I have seen five other cases in pregnant women, and all I am sorry to say proved fatal.

Case 1.—In the beginning of February, 1888, I was visiting a young lad for simple catarrhal jaundice. His sister, a married woman, æt. 28, with whom he lived, the mother of one boy and now about seven months pregnant, suddenly became alarmed lest it might be infectious, and although everything was said to pacify her feelings the usual symptoms of jaundice were, to my astonishment, observed in a week. During the first six days there was nothing particular to note, and I looked on the case as being similar to her brother's, who was now convalescent. On the 7th day she was somewhat drowsy, on the 8th in a state of stupor and semi-coma with delirium, tossing about in bed, occasionally screaming out as if in pains, and in the evening gave birth to a living child which also was jaundiced and lived seven days. On the 9th day stupor deepened into profound coma, from which nothing would rouse her—with heavy quick breathing—pulse, 115°, and temp., 102°, and Dr. Hill, who then kindly saw her, agreed with me that the symptoms were those arising from uræmic poisoning. The urine was, however, not scanty; the motions from the bowels which had been constipated were of a pale yellow colour, and evidently contained a fair amount of bile. Liver dulness was reduced to two fingers' breadth, although at the time an atrophied state of the liver did not occur to us. On the following or 10th day from the first appearance of jaundice the coma was, if possible, more intense, the muscles of the extremities rigid, and in the evening she died.

I confess I was puzzled as to the precise cause of death, and being allowed to make a *post-mortem* examination I found the liver very soft, of a yellow colour, and although I did not have it weighed it seemed to be about half its ordinary size. The spleen was pulpy and kidneys healthy. I am sorry the urine was not specially examined for leucin and tyrosin, but from the general symptoms previous to death and *post-mortem* appearances there can be no doubt she died from acute atrophy of the liver.

Case 2.—Mrs. B., æt. 25, mother of one child, and now in 6th month of pregnancy, sent for me on 16th June, 1889. She expressed herself as feeling well, for some months had never been in better health, but wished to consult me about the state of her urine which had been dark in colour for two weeks. She vomited some bile the previous day, and it may be well to state here that when previously pregnant she frequently had "bilious attacks," and that with this one exception these were entirely absent in this pregnancy. The bowels were constipated, and motions light in colour. The skin and conjunctiva were yellow, but the colouring was so faint that she did not recognize it before. Altogether she seemed to be suffering from ordinary catarrhal jaundice, which was very prevalent at that particular time.

There was no further change till the 13th when she complained of giddiness, pain over the epigastrium, and frequent vomiting, the stomach being unable to retain the simplest article of diet—the vomited matter being of a bilious character mixed with food.

The signs of jaundice were somewhat more intense, and examination of the liver showed that its dulness commenced about an inch above the edge of the ribs. The urine, of saffron colour, was of 1010 sp. gr., acid in reaction, contained bile pigment and a trace of albumen, but no leucin nor tyrosin. At 4.30 a.m. on the 14th I was hurriedly called and informed that she had a very restless night, being in a state of violent delirium and suffering from uterine hæmorrhage. On my arrival she seemed to be asleep, opened her eyes in a bewildered manner when spoken to sharply, and utterly unconscious of her surroundings. On examination, I found that miscarriage had just taken place. The pupils were dilated and responded to light, tongue moist and furred, and temperature and pulse, which up till now were only slightly above normal, rose to 101.5° and 120° respectively. The vomiting now stopped.

At 9 a.m., and again in the evening, Dr. Thomson kindly saw the case with me and looked on the symptoms as similar to those caused by

uræmia. He made a careful examination of the liver and found it reduced in size. During the day the urine showed under the microscope globules of leucin.

On the 15th she was in a state of profound coma—breathing heavy and quick, pupils dilated and insensible to light, temperature, 101·8°, pulse, 125°, and limbs slightly rigid. The urine contained both leucin and tyrosin.

On the morning of the 16th she vomited some dark grumous fluid, and later on died in a state of general tonic rigidity.

Case 3.—On 17th June I was sent for to see Mrs. C., who it was said was dangerously ill from jaundice. On arrival I found she had just died; was told that she had suffered from jaundice for two weeks, and was seen once or twice by another medical man. She was in sixth month of pregnancy. There were no particular symptoms of danger till the morning previous to her death, when she became unconscious, and remained so till the end. This was all I could elicit from her husband. Abortion had not taken place. The usual liver dulness could not be made out except on deep percussion, nor could the liver be felt with the fingers under the ribs. No autopsy was allowed, and it would not be fair to dogmatize on a case I had seen only subsequent to death, but from the symptoms described to me, combined with almost entire absence of liver dulness, I believe the disease was that of acute atrophy of the liver.

Case 4.—Mrs. D., *ætat* 21, a strong, muscular woman, mother of one child, and now four months pregnant. When seen for the first time on the morning of 15th November, 1889, I found her in a semi-comatosed condition, apparently jaundiced, pulse and temperature normal, tongue moist and coated, pupils dilated and sensible to light. On examining the abdomen the liver dulness commenced about two inches above the edge of the ribs, and immediately faded away into the ordinary percussion note of the lungs. Indeed, no distinct liver dulness could be detected except on deep percussion. Her husband informed me that for some weeks she had been unusually irritable in temper, had some "bilious" attacks, and complained occasionally of headache and sharp pains over the stomach. The urine had been dark in colour for ten days, and bowels were constipated, but he did not know if the motions were light in colour or not. Up to the night previous to my visit she was attending generally to household duties, and was thought to be in pretty good health, the above symptoms of malaise being considered of a trivial nature, and put down to the not uncommon feelings attending pregnancy. In the evening I saw her again. She was deeply comatosed; pupils

much dilated and insensible to light; breathing 45 per minute; pulse 96; temperature, 100°, and muscles of upper and lower extremities in a state of perfect rigidity. She remained in this condition all night, moaning and screaming occasionally, and died next morning.

Being unable to swallow, no medicine could be given, and the bowels did not move from the time I first saw her, so that I do not know what amount of bile the *feces* contained. The urine was passed freely and involuntarily in bed, and I was able to obtain only about a drachm for examination. It was found to be of acid reaction and free from albumen, and of a light saffron colour. Under the microscope leucin in laminated cells was observed, but no tyrosin. Abortion did not take place, but the frequent attacks of screaming probably indicated uterine pains, and had the comatosed condition developed more slowly I have no doubt the uterus would have expelled its contents in the ordinary way.

Autopsy.—The bowels were distended with gas and entirely covered the liver, so that at first it could not be felt or seen. It was of a rhubarb yellow colour, soft throughout, especially behind, and very easily torn up by the finger. The liver structure was, to a great extent, obliterated, and appeared to be composed of fatty debris; it turned the scale at 32 oz. The spleen was congested and extremely soft; kidneys apparently healthy; I did not examine the heart or lungs. It is also a great disappointment to me now that I did not examine the various organs under the microscope.

Case 5.—Mrs. E., *æt.* 27, mother of three children, and now seven months pregnant, the youngest child being only ten months old, although three years intervened between the first and second, and also between the second and third. Sent for me on 5th December, 1889, because of acute pain in the epigastrium. Before I could arrive the pain had passed away, and at first I attributed it to the passing of a gallstone, so excessive it seemed to have been. She was sitting up and said she was now all right. She appeared slightly jaundiced, and on making enquiries informed me that for about a month she had had a poor appetite and frequently felt giddy; bowels were constipated and motions evidently deficient in bile; noticed the skin yellow that morning and water dark the previous day; generally, however, in fair health. Her husband afterwards told me that she had been somewhat irritable in temper lately, and required a good deal of coaxing and sympathy. The tongue was furred in the centre, pulse and temperature normal. Liver dulness began about an inch above the edge of the ribs.

For the next few days she was able to attend simple duties in the house, having no particular symptoms beyond those of mild catarrhal jaundice. The matter of diagnosis was, however, of some concern to me. The previous history, combined with the onset of sharp pain over the liver and diminished area of dulness of that organ, pointed to acute atrophy; but examination of the urine gave no positive information, for its sp. gr. was 1026 and it contained neither leucin nor tyrosin. Bearing in mind that in the pregnant state the liver may be seemingly diminished by pressure from below, it was no easy matter to say how the case might turn out, and I watched for the development of fresh symptoms with no little interest.

On 10th December, or fifth day from date of gastric pain, she vomited several times after eating, some dark coffee-ground-looking matter. This relieved her sickness, and in the intervals she expressed herself as feeling well, having no headache or pain anywhere, and went to bed in pretty good spirits. Next morning her husband had some difficulty in rousing her, and getting alarmed because she would not recognize the children, he came for me. On visiting her at 8 a.m. she seemed to be asleep. She opened her eyes when spoken to and put out her tongue which was moist and dirty, but appeared very stupid and drowsy, and immediately shut her eyes again. Her pupils were dilated and sensible to light. Pulse, 84; temp., 98.4°; percussion note tympanitic for two inches above the edge of the ribs. During the day she retained nothing in her stomach, and urine was passed pretty freely and involuntarily in bed. It was of 1018 sp. gr., slightly acid, contained trace of albumen and bile pigment, and both leucin and tyrosin. In the evening she became very restless and violently delirious, and occasionally screamed out sharply—the screams resembling the Hydrocephalic cry of children but evidently caused by uterine pains, for they ceased on the delivery of the child at 11 p.m. Examination of the liquor amnii revealed the presence of leucin. Next morning Dr. Marks kindly saw the case and agreed with me that the disease was that of acute atrophy of the liver. She was now fully comatosed; pupils much dilated and did not respond to light; pulse 125, temp. 101.5°; breathing heavy, 52 per minute, and muscles of the extremities rigid. The bowels moved freely from purge given the previous day, the motions being liquid and pale yellow in colour. On the following morning she died.

Autopsy.—The omentum was fragile, bowels healthy, somewhat distended with gas and contained faeces of a gray colour. Liver—yellow in colour, weighed 30 ounces; posterior part soft and friable, easily torn up and in an advanced

state of fatty degeneration; anterior part firmer; gall bladder nearly empty; bile ducts patent. Spleen, 3½ ounces in weight, oily looking, and very soft and pulpy. Kidneys, 8¼ ounces in weight, softer than in health, and stained with bile pigment. Lungs very much congested. Heart, empty on left side, right ventricle contained a small quantity of dark liquid blood. Examined under the microscope the liver cells were found almost entirely destroyed, and replaced by fatty globules and granular debris. The spleen also showed signs of fatty degeneration. The kidneys were more healthy.

In these three organs both leucin and tyrosin were observed, but in the liver and spleen I also found, to my surprise, numerous small crystals, which I have no hesitation in saying were those of xanthin. They formed rhombic tables—in some the angle being nearly a right angle, in others more obtuse and angularly oval in shape. In order to separate these three bodies from the tissues, I cut up a small piece of the liver into little bits, added some water, rubbed up well in a mortar, filtered, treated in the ordinary way with acetic acid and acetate of lead and obtained a watery solution, which on being evaporated to dryness showed xanthin as well as leucin and tyrosin under the microscope. Several chemical tests were now applied which clearly indicated their presence, but, as far as I knew, the tests that apply to one of these pretty nearly apply to all, so that I was unable further to identify and isolate xanthin from the others.

This body contains but one atom of oxygen less than uric acid, so that it is one we might naturally expect to find. It was discovered by Marcet in 1817 in a urinary calculus, and has now and again been met with in that form since then. Scherer was the first to discover it in the blood spleen and muscles, but as far as my reading goes I am not aware that it has ever been found specially in acute atrophy of the liver. This is why I made a careful chemical analysis of the liver, in order that there might be no doubt of its existence, and for that reason I also examined the spleen in a similar manner, and with almost similar results. Xanthin appeared to be more plentiful in the spleen than in the liver. I should mention that I have never been able to detect it in the urine. It is supposed to arise in the diseased state from abnormal metabolism of muscular tissue, while leucin and tyrosin come from "defective metamorphosis of the nitrogenous elements of food," and if that be so we have pretty conclusive proof that the liver, and perhaps also the spleen, have some important functions to perform in connection with albuminoid metabolism from both sources.

Case 6.—Mrs. F. came to my house on 16th December and gave the following account of herself:—In fair health, though generally subject to headaches; now three months pregnant. Three days ago she complained of a sharp pain under the liver which passed away in a few hours; now suffered from headache and giddiness, pain over the epigastrium and general gastric disturbance; was frequently sick and vomited a watery-looking fluid mixed with flakes of dark mucus; observed her skin yellow for the first time this morning and water dark in colour for ten days. The bowels were constipated, motions light in colour, though not chalky. I gave her an alkaline mixture and asked her to return in a day or two.

Three days after her husband came hurriedly for me, said she had suddenly become violently delirious and could not be kept in bed. When I visited her she was moaning and tumbling about in bed and semi-comatosed; pupils much dilated and responded but slightly to light; pulse 130, temp. 99; skin jaundiced, though not intensely so. On examination I found that the fœtus had come away and the placenta was lying in the vagina. The liver dulness was reduced to two fingers' breadth over the right lobe, entirely absent over the left.

I was informed that up till this morning she remained in pretty much the same condition as when I last saw her; vomited once some dark looking fluid the previous day; that delirium came on this morning previous to miscarriage and she became unconscious immediately after.

I drew off her water. It was of dark amber colour, of 1018 sp. gr., acid, free from albumen and contained bile, though not to any great extent; under the microscope no leucin nor tyrosin was observed.

At 8 p.m. she was deeply comatosed, perspiring freely through action of pilocarpine, which I injected during my previous visit, pupils not quite so much dilated, probably from same cause; pulse 120, temp. 101°; breathing heavy, 40 per minute. At 11 p.m. she died.

This was the only case of the kind I attended in which there was no rigidity of the muscles of the upper and lower extremities previous to death.

Autopsy.—Bowels natural, contents liquid and grayish in colour.

Liver of rhubarb yellow colour, very soft and friable. Its structure was greatly obliterated—the lobules being very indistinctly marked. It turned the scale at 30 ounces. Curiously enough there was a small lobe about the size of a hen's egg near the middle of the right lobe and coming from its posterior and under surface of same consistence as the rest of the liver. The gall bladder was nearly empty.

Spleen extremely soft and pulpy and wrinkled on the surface, weighed 8½ ounces.

Kidneys soft and smaller than in health, weighed 3½ ounces.

Heart healthy—both sides contained very small quantity of dark liquid blood.

Lungs much congested.

Brain natural.

Examined under the microscope the liver and spleen, and to a less extent the kidneys were in a state of fatty degeneration, and in the two former organs leucin, tyrosin, and xanthin were observed.

Diagnosis.—Murchison recognizes three forms of jaundice caused by pregnancy—in the early stage due to congestion of the liver from suppression of the catamenia, in the more advanced stage from pressure of the uterus on the bile ducts and from acute atrophy. At the same time they are of course subject to jaundice from causes that are common in the non-pregnant state, for simple catarrhal jaundice in pregnant women is not unfrequently met with.

Jaundice from congestion, due to suppression of the menses, I have never seen. I have had one case caused by pressure on the bile ducts from the gravid uterus, and the symptoms subsided immediately on the birth of the child. According to my experience the question of diagnosis lies, in the great majority of cases, between catarrhal jaundice and acute atrophy, and in the early stage it is no easy matter to say whether it is of this simple nature or of the more virulent type. In the absence of leucin or tyrosin little information can be got from examination of the urine, for in both the sp. gr. may be the same, from 1010 upwards, both may be slightly albuminous and contain bile pigment. The colour is, however, usually much more intense in the former. In catarrhal jaundice there is general gastric disturbance, uneasiness and vomiting—in acute atrophy these are usually combined with occasional sharp pains and tenderness over the epigastrium. In the former the skin is very distinctly yellow when first seen and has been observed for sometime—in the latter the skin is not much altered in colour, and perhaps has not been noticed at all until the patient's attention is brought to it. In the former you are consulted for the jaundiced state; in the latter for gastric pain and vomiting.

Examination of the liver generally gives diminished area of dulness in acute atrophy. If still doubtful you are not left long in this unenviable condition of ignorance, for a hurried call to say that your patient is in pain and delirious reveals at once the nature of this remarkable disease. As far as I have observed, this state of delirium comes on from three to six days after the

skin becomes yellow, and if absent for about ten days after your first consultation, even though the liver may appear smaller on percussion, I would, in the absence of positive urinary tests be inclined to put it down to the simple form of jaundice. In one case of jaundice in the pregnant state which I attended the patient was for several days absent-minded during the day, and in a condition of stupor and slightly delirious at night, and the liver seemed somewhat reduced in size, but she had been ill for two or three weeks; there was no acute gastric pain and the jaundice was very well marked. It was one of catarrhal jaundice, and in a short time she was convalescent. Three months after she gave birth to a living healthy child.

I cannot imagine it possible, from the present state of our knowledge, for a patient to recover from acute atrophy of the liver.

Treatment.—I know of none that is of any avail. In the preliminary stage I have given with but temporary benefit, euonymin, the ordinary magnesia and alkaline mixtures, the latter in effervescence, combined with mild saline purgatives and an occasional smart purge of calomel and jalap. The food should be as non-albuminous as possible, so as to give us a minimum of its products in the system. Is it possible, as has been suggested, that the inability of the liver to metamorphose the peptones from digestion allows of the entrance into the blood of ptomaines, and that these are the prime cause of the so-called typhoid state of acute atrophy? If this be so the matter of diet may be an important one. When delirium and coma supervene treatment in my hands has been unavailing. In one case I injected pilocarpine, but though it caused slight contraction of pupils and copious perspiration no particular benefit was obtained. With regard to the question of inducing premature labour, I have never resorted to it in these cases, and am very doubtful that it should affect the progress of the disease. It could at any rate do so only in the very early stage, and then the matter of diagnosis is so undecided that I do not think it would be justifiable.

Remarks:—In connection with this very interesting disease I would venture to make the following observations:—

1. Age.—All my cases occurred between the ages of 21 and 28.

2. Sex.—They have all been in married women in pregnancy. Out of 33 cases recorded by Frerichs 22 were females, and of these one-half were pregnant. Four of my cases miscarried before death.

3. Season and locality.—Two appeared in June, one in November, two in December, and one in February. Four were in comfortable houses on

elevated localities in various suburbs of the town, one lived on low swampy ground, and one in a crowded part of the town. It would be well to remember that the rainfall in this district has been unusually high for the last twelve months, and that many parts of Brisbane have frequently been in a flooded condition.

4. Acute atrophy of the liver is not the cause of the disease, but is merely a local manifestation of a generally morbid tissue, metabolism. The disease might as correctly be called acute atrophy of the spleen, for this organ, in the three cases I carefully examined, was but half its ordinary size and weight.

5. The prevalence of this disease in pregnancy, with its altered condition of blood and marked susceptibility to nervous influences, tend to the belief that these two factors are at the root of this condition that results in acute atrophy of the liver and spleen. In one case it was purely traced to shock to the nervous system, and in the absence of this, is it possible that the great fear and anxiety with which some married women, especially in this hot climate, look forward to the birth of another child may supply us with the usual exciting cause.

6. Through this aberration of the nervous system in a vitiated state of the blood, the nutrition of the various organs is affected and their physiological activity retarded. The hepatic, splenic and renal cells, and probably the cells of other organs and tissues are altered, undergo fatty degeneration, and the organs or tissue atrophy. In consequence of this, tissue and blood metamorphosis is interfered with, the albuminoids are not completely oxidized into the more soluble products, urea and uric acid, and the less oxydised bodies—leucin, tyrosin, and xanthin—take their place.

7. The blood also undergoes changes. Examined under the microscope it is seen that the plasma is full of minute granules, that the red corpuscles lose their regular outline, are more or less shrivelled up and granular in appearance. The white corpuscles also are of very irregular shape, and their cell wall in many cases is incomplete. Whether these changes appear antecedent to or are dependent on the structural and physiological changes in the various organs I do not know. They evidently indicate abnormal and deficient evolution and dissolution of the corpuscles of the blood.

8. The cerebral symptoms observed later on in the disease are not caused by bile poisoning, for in the worst and most rapid cases the jaundice is least intense. The suddenness of their onset is suggestive of some rapidly-developed poison, such as ptomaines, absorbed into the system through

the inability of the atrophied and disorganized liver to destroy them, or leucomaines generated in the blood through "abnormal metabolism of albuminous matters."*

If we refer to the very interesting article in the *British Medical Journal* for 27th July, 1889, by Sydney Martin, on the effect of certain vegetable alkaloids on animal life, we shall find in it some resemblance to the symptoms observed in this disease:—"If the abovementioned dose of globulin be injected into the rat, symptoms of poisoning begin to appear in about six hours, the animal then seems languid and in a condition impossible to distinguish from sleepiness. It continues in this state, making no voluntary movements, *irresponsive to slight external stimuli and with half shut eyes*. It lies huddled up in its cage, the breathing becomes more rapid and bloody motions are passed shortly before death, which occurs in about twenty-four hours after inoculation. *If the animal is with young it aborts.*" Proteids of this nature, however, cause a fall of body temperature, whereas in acute atrophy we have, on the advent of cerebral symptoms, an elevation of temperature. In the meantime we have to fall back, as Murchison says, "on impaired or deranged metabolism in the blood and tissues and retention in the system of those products of metamorphosis which ought to be eliminated by the kidneys."

9. Acute atrophy of the liver might, with more significance, be designated "acute fatty degeneration of the liver."

* Since the above was written I have analysed, after the manner recommended by Luff, fragments of the liver spleen and brain, with the object of ascertaining the presence of an alkaloid, and have obtained a cream coloured amorphous substance, which gave the following reactions:—

Hydrochloric Acid	Orange yellow.
Tannic Acid	Light brown.
Iodine	Madder brown.
Mercuric and Potassic Iodide..	Faint yellowish white.
Ferric Acid	Faint yellow.
Chloride of Gold	NIL

The amount of this substance was necessarily very small—too small for chemical analysis—so that its nature or composition I do not know.

CASE OF ANEURISM OF POSTERIOR AURICULAR ARTERY.

By ÆNEAS J. McDONNELL, M.B., CH. M. (SYD.),
LATE RESIDENT SURGEON TOOWOOMBA HOSPITAL, QUEENSLAND.

A.C., *æt.* 46, was sent in by Dr. Sheaf on January 10th, 1890.

Stated that in 1855, when learning to crack a whip, the end caught him in the middle of the back of the ear. Something seemed to give way, but the skin was not broken. A lump gradually

grew in which patient could feel pulsation and hear a whizzing sound in.

Towards the end of last year it was as large as a pigeon's egg. A little red pimple appeared on the swelling, which burst at this spot on December 13th, 1889. Came into town, a distance of 24 miles, by train, holding ear between finger and thumb. Saw a medical man who "tied a string" round the spot, and told him it would need an operation at no distant period. After this, state of affairs much the same as previously, but noticed spot where rupture occurred to be much thinner than previously, and fearing a repetition, consulted Dr. Sheaf on January 7th.

On examination the right ear has a swelling about the size of a pigeon's egg, of irregular shape, at the posterior middle part of the edge of the helix; this is of a dark colour; pulsates markedly; a whirring bruit is heard through the stethoscope, and a thrill is felt very plainly.

The whole ear is seen to move synchronously with the beat of the heart.

The posterior auricular artery on this side is larger and more tortuous than the other.

On firm pressure over the artery the swelling is completely emptied and shrinks up; the wall in one place seems to be not thinner than a sheet of blotting paper. On consultation with Dr. Sheaf we decided to try first the effect of pressure.

The difficulty was to get some suitable way of compressing the artery against the ear; but a Wilcox forceps with slide catch was found to answer the purpose, the ends being well padded with wool, and the screw and slide catch being used to regulate the pressure.

On January 15th pressure was applied for four or five hours; but on the removal of the forceps the aneurism reappeared, so it was determined to keep constant pressure on the artery, and at the same time a strip of lead folded on itself was used to keep the walls of the aneurism in apposition.

The pressure of the forceps became very painful after a few hours; but the man was resolved to stand any pain rather than submit to ligature.

This was kept up for four days, and was then removed owing to ulceration, by the movements of the forceps, of the surfaces pressed on, it being impossible to keep the man quiet.

The aneurism was then found to be completely cured, but the posterior auricular artery seemed to be larger, and was about the size of a slate pencil for about a quarter of an inch beyond where the pressure had been.

Dressed the ulcerated surfaces with Ung. boracis.

About four days afterwards there was a hæmorrhage from the posterior ulcer, about one ounce of blood being lost; but this was stopped by pressure on the artery.

On February 3rd was discharged with the ulcers nearly healed.

Told to watch himself carefully and report again in a month.

March 23rd.—Both ears exactly the same. The cicatrix of the ulcer has pressed in the artery and almost obliterated it. On feeling deeply between the ear and the mastoid process the artery may be felt slightly larger on the affected side, otherwise no apparent difference in the ears.

CLINICAL NOTES ON SOME CASES OF RUSSIAN INFLUENZA.

By CLIFTON STURT, L.R.C.P., ETC., GOVERNMENT MEDICAL OFFICER, BULLI AND COAL CLIFF DISTRICT, N.S.W.

THE first case of Influenza (La Grippe) which came under my observation occurred on April 15th, and I have every reason to believe that this was one of the first cases occurring in this district.

Mrs. J. H., æt. 56, married, no children, had always enjoyed good health. On April 15th, whilst on a visit to a friend at no great distance from here she was suddenly seized with a feeling of languor and malaise, accompanied by a feeling of chilliness. A few hours later I saw her and found her suffering from extreme prostration, and complaining of intense pain in the calves of her legs, with frontal headache. Temperature, 102; pulse, 110, rapid, but soft. Her eyes were suffused, and there was some lachrymation, the surrounding skin being a little "puffy" and inflamed. Her skin was hot and burning; there was no cough. I ordered her to go to bed, to take two mild aperient pills, and the following mixture:—

R. Pot. Nit. grs. 48
Liq. Am. Ac. conc. ʒss.
Vin. Ip. ʒij.
Aq. Camph. ʒiv.
Aq. Chlorof. ad. ʒ x ij.
Mft. mist.
Sign.

"Two table-spoonfuls to be taken every four hours."

She slept very badly that night, complaining bitterly of the headache and of the pain in the calves of her legs.

Next day there was no amelioration of her symptoms.

On April 17, two days from the time she was attacked, the symptoms abated, but she did not "feel well" for some nine days after.

She had not exposed herself to any draughts, and was up to the time of the attack in good

health. She could not account for her illness through any indiscretion on her part.

W. D., æt. 50, engineer, in good health, whilst at work at the Bulli Coal Mining Company's Mine on April 23rd, was suddenly seized with a feeling of great weakness, attended with slight rigors, and was unable to go on with his work. He came home at 2 o'clock, and the same evening sent for me. I was unable to attend, but advised his wife to get him to bed and give him a warm drink when he retired. The next morning I saw him. He complained very much of the pains he had felt in his legs, and the way in which his head ached. He had lost his appetite, and his tongue was coated and dry. All night long his skin had been hot and burning, and although he put an extra blanket on his bed he had not been able to get his skin to perspire. I prescribed a mixture of quinine and sulphuric acid. He was "bad" for a day or two, off work, but gradually the pains left him, and three days later he was able to return to his work, although he did not feel quite well.

W. H. R., æt. 9, on April 24, whilst returning from school, felt "very bad," and had to rest two or three times on his half mile journey home. He felt great pain in the front part of his head which made him feel "very sick," and had also pains in his limbs. During his journey he had several shivering fits which continued "by fits and starts" all that evening, and indeed for the next two days. I saw him in the evening, and prescribed a mixture containing salicylate of soda and liquor ammon. acetat. He looked flushed and feverish, his skin being hot and burning, but without having a feeling of chilliness and a great desire to remain by the fire. His mother said he was delirious all night, and she could not keep him still. The next day he was much the same, still feeling chilly and having a desire to remain near the fire. His temperature at 6 p.m. was 103.6, with pulse weak, 104. This night he was again delirious, but better next morning. He did not have any further bad symptoms, and rapidly convalesced.

These are only a few cases of which I have kept brief notes.

Since the 15th April, when the first case occurred, I have seen nearly fifty cases.

The most prominent symptoms of the disease as observed by myself are as follows:—Sudden onset of fever with moderately high temperature, and weak pulse, with headache and nervous prostration, out of all proportion to the other symptoms; pain in the limbs and symptoms which point to affection either of the respiratory or gastro-intestinal tracts.

These symptoms differ from those of epidemic catarrh in many important particulars. Catarrhal

symptoms in the cases under my observation being the exception, not by any means the rule.

In no case could I ascertain that there was any definite period of incubation, the invasion of the disease being very sudden.

The fever which was ushered in and accompanied by rigors, and a feeling of chilliness, rapidly developed, reaching in a few hours as high as 103.6. The morning remissions were only slight; the fever rarely lasted more than two, or at most, three days, and as rapidly disappeared.

The skin was, for the first two days, whilst the fever lasted, hot and burning, and *the pulse, varying from 100 to 120 per minute*, was weak, and sometimes irregular. This weakness of the pulse was observable for several days. Most patients complained that they could not make themselves feel warm, even when near a good fire.

The headache was almost always very intense, and *was present in all cases*. It was frontal in character, dull and aching, not throbbing with a sensation of fulness, as found in cases of sporadic influenza, and accompanied in some instances by ocular pain. It was persistent even after the abatement of the fever, and if the patient attempted to get up too soon, liable to return as bad as ever.

In the cases of two children, C. and A. S., brothers, the headache was very intense and followed by *fits* which were epileptiform in character. Epilepsy was hereditary in the family, and the elder brother had had epileptic fits on two or three previous occasions.

In some cases there was found a feeling of nausea with retching which appeared to be of cerebral origin, as it was not affected by taking food. No actual vomiting took place.

In a very few cases there was suffusion of the eyes with lachrymation, but it only lasted whilst the fever continued, and disappeared entirely with it.

In one or two cases there was present some catarrh of the respiratory tract, and in one only bronchitis was a complication which threatened to end fatally.

The absence in most cases of any catarrh, strictly speaking, and of cough presented to my mind a point strongly diagnostic of the disease.

A few cases presented marked gastro-intestinal symptoms. Nausea, vomiting, colicky pains, and constipation, with a foul coated dry tongue and the usual nervous symptoms.

In all cases the bodily pains were chiefly referred to the back, loins, thighs and calves of the legs. They were very intense, and persisted long after the fever had abated.

The prostration and nervous depression accompanying these symptoms were out of all propor-

tion to them. From the first the prostration was severe, and lasted even after all other symptoms had disappeared.

I have been able to trace the source of infection in one or two instances to a visit to Sydney, and these instances were amongst the first which appeared.

In one family the son contracted the disease when on a visit to Sydney, and since he came home six of the family have suffered from the disease.

The majority of cases, however, cannot be said to have been exposed to the contagion of the disease in a like manner, and these cases were of a more striking character than the former.

With regard to treatment. I have found no drug that I have tried of more value than salicylate of soda in full doses when given at the onset of the disease. I have given it in combination with liquor ammoniæ acetatis and chloroform water. It cuts short all the most aggravated symptoms, lessening the fever, relieving the headache and muscular pains, and, combined with the acetate of ammonia, appearing to promote the action of the skin. To combat the resulting weakness and depression with anorexia I find nothing to equal quinine in small doses either alone or in combination with iron. In cases where nervous symptoms were most prominent I relied chiefly on the well-known action of bromide of potassium with eminently satisfactory results.

Diaphoretus I found were of no value.

In the case which was complicated with bronchitis I treated the bronchitis and not "La Grippe."

In all cases I have recommended rest in bed and a light diet. In some cases stimulants were necessary to combat the depression existing.

Looking at the cases which have come under my notice from a general point of view I think they may conveniently be classified under three heads:—

I. Cases presenting purely nervous symptoms.

II. Cases presenting nervous symptoms, but in addition presenting symptoms pointing to implication of the respiratory tract.

III. Cases presenting nervous symptoms, but in addition presenting symptoms pointing to implication of the gastro-intestinal tract.

I believe that the disease is due to the action of a specific micro-organism, and is chiefly disseminated by means of the air.

I regret exceedingly that I have neither the means nor the time to devote to investigating this point, but I have no fear but that my surmises will sooner or later be confirmed by more fortunate observers.

Bulli, N.S. Wales, May 7, 1890.

TRAUMATIC CATARACT.*

By E. MATTHEWS OWENS, HON. OPHTHALMIC SURGEON TO THE CHILDREN'S HOSPITAL, BRISBANE, ALSO IPSWICH AND TOOWOOMBA HOSPITALS, QUEENSLAND.

It is scarcely necessary to state that "Traumatic Cataract" is the name given to that disease of the eye in which blindness is caused by loss of transparency in the lens; such loss of transparency may be caused by any shock to the eye which ruptures the capsule, or by a blow with any hard substance, or a punctured wound that touches the lens. There can be no doubt that any violent disturbance of the lens may also cause, months later, traumatic cataract. In such cases there may be no lesion whatever of the capsule.

Before going further it may be as well to preface what I have to say respecting changes in structure of the crystalline lens by a description of that part in its natural and healthy state, also a few words about the anterior chamber will not be out of place. It is well known that the lens is a double convex body lying in apposition with the whole posterior surface of the iris, which it renders slightly convex. The anterior surface of the lens is transparent and elliptical, the posterior parabolic. The anterior surface should, according to Krause, resemble a surface produced by an ellipse revolving about its shorter axis. But the central portion may still be regarded as spherical. Its curvature varies, being, according to Helmholtz, 10 millimetres; Knapp says 7.9 millimetres. The thickness of the crystalline lens may be said to vary, according to Von Reus, from 3.02 mm. to 4.19 mm.

Helmholtz states that the posterior surface of the crystalline lens has a radius of curvature of 6.0 mm. The same authority gives the greatest curvature a radius of 5.18 mm. The structure of the crystalline lens is not homogenous, but may be said to be made up of a great number of superimposed layers, whose curvatures increase in passing from the surface toward the centre, so that the nucleus is nearly spherical. The substance of the lens consists of fibres, which, in a fresh state, appear as rather thick bands striped longitudinally. There are also some small transverse grooves surrounding the edge, but usually are only visible in places where a fibre has been doubled backwards. The fibres of the lens appear as hexagons, of which the two sides parallel to the surfaces of the lens are considerably larger than either of the four others which face towards its edges. These fibres vary considerably in con-

sistency as they pass from the periphery to the centre. In the vicinity of the capsule they are soft, tear readily and give exit to a central portion, which is less consistent, so that the term lenticular canals might almost be applied to them; but towards the centre their consistency increases to such a degree that in elderly persons it amounts almost to brittleness. The colour of the lens is different at different periods of life. In the fœtus it is often of a reddish colour, at birth and in infancy it appears opaque or opaline, in youth it is perfectly transparent, and in the more advanced periods of life acquires a yellowish or amber tint. These varieties in colour are not visible, unless the lens be removed from the eye, until the colour becomes so deep in old age as to diminish the transparency when it appears opaque or milky, or resembling the transparent horn used for lanterns.

The crystalline lens is a little heavier than water; if it be placed with the capsule attached to the hyaloid in water the following day it will be found to be slightly opaque and split into several portions by fissures extending from the centre to the circumference. This appearance may be rendered more obvious by immersion in spirit or the addition of a few drops of acetic acid to the water. If a lens thus circumstanced be allowed to remain some days in water it continues to expand and unfold itself, and if delicately touched and opened by the point of a needle then carefully transferred to spirit, and as it hardens is still more unravelled by dissection, it ultimately presents a remarkably fibrous or tufted appearance. It was my intention, had I been able to be present at the Congress, to show some fresh specimens of lenses under different treatment. The knowledge of the manner in which the lens is secured at the sides by the zonula is of the greatest practical value. The zonula arises from the ora serrata—covers the processes and separating from them passes towards the edges of the lens. In a longitudinal section of the eye the edge of the lens is seen to be included in a triangle. The apex of this triangle is formed by that portion of the zonula which is in contact with the ciliary processes. I may remark that the zonula itself does not open out at the edges of the lens in such a way as to form a canal between its layers. I have dwelt long enough on the lens, but the capsule is of so much importance that I must briefly refer to some of its chief characteristics.

The capsule of the lens may be said to be strong, elastic, and in health perfectly transparent. It is composed of tissue exactly similar to the elastic layer (Descemet's) of the cornea. It is thicker in front than behind, for the sake, evi-

* This paper was prepared for the Ophthalmologic Section at the late Intercolonial Congress, but in transit went astray, and so arrived too late to be read.

dently, of more effective support. There is no vascular connection between the lens and its capsule. I cannot but think that we must agree with some of the older writers and look upon the capsule as of cartilaginous structure. I think they were right from the following reasons: *First*, its elasticity, which causes it to assume a peculiar appearance when the lens has been removed, not falling loose into folds as other membranes, but coiled in different directions; or, if the lens be removed, by opening the capsule behind and withdrawing it through the vitreous humour, allowing the water in which the part is immersed to replace the lens, the capsule will preserve in a great degree its original form. *Secondly*, from the density and firmness of its texture, which may be well ascertained by puncturing with a needle or cutting it on a solid body. *Thirdly*, from its permanent transparency, which it does not lose except on the application of strong acid or boiling water, and then only in a slight degree, maceration in water for some months or immersion in spirit having little or no effect upon it. If the lens be removed from the eye of a boiled fish the capsule may be raised by the point of a pin and be still found almost perfectly transparent. This combination of density and transparency gives the capsule a peculiar sparkling appearance in water, in consequence of the reflection of light from its surface, resembling a portion of thin glass which has assumed an irregular form while soft. This sparkling may be considered very characteristic of this structure. The properties I have enumerated cannot be denied but to belong very closely to cartilage. But it may be said cartilage is not transparent; but the cartilage of joints is semi-transparent, and if divided into very thin portions or layers it is sufficiently pellucid to permit the perception of dark objects behind it; it is almost perfectly transparent in the sclerotic of birds and fishes. If the soft consistency of the external part of the lens be considered the necessity of a capsule capable itself of preserving a determinate form is obvious. If the lens were enclosed in a capsule such as that which envelops the vitreous its surface could not be expected to present the necessary regular and permanent curvature, nor could we expect that if the form of the lens were changed it could be restored without this provision of an elastic capsule.

It has been said by many writers that a watery fluid is interposed between the body of the lens and its capsule. Morgagni was, I think, the author of this, but later researches have quite disproved the existence of this fluid. It was this erroneous notion that gave rise to the adoption of an unsustained and improbable conclusion that

the lens has no vital connection with its capsule, and consequently must be produced and preserved by some process analogous to secretion. That there is close connection between capsule and lens may be proved conclusively by the following experiment: Remove the cornea and iris from an eye within a few hours of death and place it in water, then with a pair of sharp-pointed scissors divide the capsule all round the circumference of the lens, taking care that the division is made behind the anterior convexity so that the lens cannot be retained by any portion of the capsule supporting it in front; next, invert the eye, holding it by the optic nerve, when it will be found that the lens cannot be displaced by agitation from the capsule. I think we may say that often in extracting we have encountered considerable difficulty in detaching the lens from its situation after the capsule has been freely opened; this difficulty may be fairly put down as referable to the natural connection of lens and capsule.

The Anterior Chamber has an important bearing in traumatic cataract, and, therefore, I cannot pass on to the more practical part of my subject without calling attention to a few facts concerning it. The distance from the anterior surface of the cornea to the anterior surface of the lens is 3.6 mm. Deducting the thickness of the cornea, 0.9 mm., we obtain 2.7 mm. as the depth of the anterior chamber. It is filled with a few drops of clear watery fluid of alkaline reaction. This fluid completely fills up the space between the cornea and lens. The iris floats freely in it, and divides the space into two chambers of unequal size. The posterior is much the smaller, and has an important bearing in the after-effects of "extraction" in liability of secondary cataract formation. The anterior chamber is lined by a serous membrane, a layer of very fine epithelium is on the posterior surface of the cornea, but no serous membrane can be found either on the iris or capsule of the lens. How thankful we often are for the rapidity with which the anterior chamber absorbs and secretes fluid. In all injuries to the lens the shape of the anterior chamber should be most carefully noted; for not only will your treatment be guided by such inspection but your prognosis also.

I now come to the disease itself and its treatment. If a patient presents himself for an opinion who is suffering from traumatic cataract, but the diseased eye is quiescent, should he be operated upon? I say most emphatically, *yes*; for by disease or accident the good eye may be lost, and then it will perhaps be too late to operate upon the cataractous eye. It cannot be denied that however brilliant the operation may be disappointment of the patient will often follow, for he

thinks that he ought to see quite as well with his aphakic eye as with the other. As we well know an aphakic eye can see clearly only at the distance for which it is adapted by the length of its axis and curvature of its cornea, with or without the aid of suitable lenses. Then, too, there is the diplopia, which takes some time and practice for an aphakic patient to get used to. I am sure there are none of my hearers who cannot sympathize with the following: A patient, on whom you think (and really have) done a brilliant operation, comes back full of grumbling and discontent. I have had more gratitude from enucleation cases than I have ever had from cataract patients. Though I make a point of *trying* to instil into their minds exactly what will happen, yet months after I am met with this remark, "Oh, I am so disappointed; I thought I should have seen better." When I get a grumbling, discontented patient I am reminded of an anecdote told me by my great friend, Critchett, of his father, who maintained that physicians were in much better relationship to their patients than specialists, for when a physician makes a mistake or has an unsatisfactory case the patient generally goes where no tales are told; but the poor specialist is liable to have his patient going about the world for many years, pulling down the lower eyelid of an empty socket, and saying, as a celebrated old Duchess used to, "See what that old villain, Critchett, did for me!" Opacity of the lens may be months before it shows itself after the injury, or it may be only a few minutes. As I shall enumerate a few cases at the end of the paper I will say no more about this at present. As many cases of traumatic cataract are complicated with subluxation of the lens, and as this requires very different treatment I will take, first, Treatment of Simple Cataract from Injury.

Should an iridectomy be performed as part of the treatment for traumatic cataract?—to this I said yes, but the consideration as to when it should be done requires some thought. As a rule I would do the iridectomy as a preliminary step and remove the lens later on; let the iridectomy (if there is any irritation) be as large as possible; and on no consideration meddle with the injured lens, and abstain most carefully from using atropine—I really think if atropine were blotted out from the Ophthalmologic Materia Medica it would be good; for when a man has a little knowledge, it is atropine! atropine! atropine! not knowing or thinking whether, say there is a punctured wound at centre or periphery of cornea. Let there be no delay in the iridectomy, for it must not be forgotten that you have a swollen lens to deal with. The tension of the eyeball, state of sight and of the field of vision

must be frequently examined, so that glaucoma may be recognized in its earliest stage; but nearly all anxiety on this score may be put on one side if an early iridectomy be performed, so that, taken as a rule, always perform iridectomy in injuries to the lens, and do it as early as possible.

The eye having quieted down after the iridectomy we can extract at our leisure, either by linear extraction, by the scoop, by suction or absorption. Some authors recommend, if the wound of lens be of slight extent and the patient young, the cataract may be left to absorption. This, of course, is right in a very young child, for there is danger of a child not being kept quiet after an operation. If there should be a foreign body in the lens the best mode of extraction is undoubtedly by the scoop, passing it well behind extracting lens and foreign body together, but given that there is no foreign body I am in favour of extracting by Pridgen Teale's suction curette, as I have used it now 25 times within the last two years without a single unsatisfactory case.† I have reason to speak highly of it. The principal point in using this instrument is to see that the cataract is fluid enough to extract. I generally needle any part that I am not sure about a few days before the operation; this simplifies the operation immensely, and this is why the preliminary iridectomy is so useful, giving you plenty of time and doing away with nearly all fear of iritis or irido-choroiditis. In operating I do not tear open the capsule by needles, as is recommended; I use a medium-sized keratome or bent needle, puncturing the cornea through the cicatrix of iridectomy wound, and passing the point of the keratome in front just at the edge of the lens, continuing the incision to the centre of the lens. This gives plenty of room in the capsule for the point of the curette to go into the centre of the lens. It is a mistake not to make the wound in the cornea big enough, for if you have to use any force to get the point of the curette into the anterior chamber the parts are bruised, and the wound does not heal so readily. Except with young patients I use cocaine both in the iridectomy and second operation. I have only two complaints against cocaine—one that it undoubtedly increases tension, and, secondly, it hardens the tissues, making the section in the cornea more difficult. Both after the iridectomy and extraction I use eserine freely. There is another point about cocaine that I would mention, that is, the superficial surface of the cornea undoubtedly is very easily abraded. A medical man

† Since this paper was written I have used the suction curette 15 times, with equally good results as in the 25 previous cases.—E. M. O., May 1st, 1890.

on whose patient I had operated, noticing the glazed look of the cornea, while my back was turned wiped the eye, and to his horror wiped off nearly the whole superficial layer of the cornea, and was very unhappy until I assured him that no ill result would follow; but still it is as well to manipulate the cornea as little as possible when it is deeply anæsthetized by cocaine. I do not seek to have the pupil quite black after the operation is finished, for the wound in the capsule is so large that what is left of the lens soon absorbs; in fact it is well for it to do so as the parts adapt themselves to the loss of the lens better. If the capsule gives any after-trouble in the way of secondary cataract a touch of the needle soon overcomes that. These are much lesser evils than to go hunting all over the eye after stray pieces of the lens with the point of the curette.

Cataract with Dislocation.—If what I said before about preliminary iridectomy was true in simple traumatic cataract, in the above it is doubly so. It must be remembered that the anterior chamber is of unequal depth in dislocation, being more or less destroyed on one side, either because the iris has been forced against the cornea or a synechia has been formed at the time of the injury. In such a case you most likely will have periorbital neuralgia, and attending to the lens only will not stop the mischief. When a case of subluxation presents itself let there be no delay in the performance of an iridectomy with free instillations of eserine, and avoid atropine as the very devil. Please pardon me, but I feel strongly, for I have seen so much abuse of this mydriatic. It must not be forgotten that an iridectomy is a very simple operation, and once done you have plenty of time to work out what will be the next step towards giving your patient useful vision, and most certainly extraction of a dislocated lens is not so easy as in simple traumatic cataract; if the dislocation is but slight it can be extracted by the curette, but if it is extensive, when you attempt to puncture the capsule the whole lens is pushed backwards, besides, too, there is a danger of losing vitreous. If a large iridectomy has been performed, the iris being excised right up to the periphery, I much prefer to fix the lens with one needle and rupture the capsule freely with a second, this operation not being done until you feel pretty sure that the whole lens has become quite soft and fluid. You need fear no untoward effects from this, for you are protected from any fear of glaucoma by your iridectomy and eserine; the latter must be used freely. But every case must be treated on its merits, and what may be accomplished in one case may have to be entirely modified in a second.

Before concluding I will briefly narrate a few cases from my note-book that either had something abnormal or else presented some unusual difficulty at the time of the operation. I would esteem it a favour if I am well criticized.

Case 1.—A school boy was sent to me by Dr. Lightoller, of Ipswich, on February 22, 1886, with the following history: Three days before was struck below the lower eyelid with a piece of slate; the cut was still visible when I saw him; there was no swelling of eyelids; slight ptosis, but pupil widely dilated and quite insensible to light. By ophthalmoscope nothing whatever abnormal could be discovered; the vessels of the retina were normal; vision was affected to the extent of the paralysis of accommodation; I ordered eserine, strychnia, dark glasses, and perfect quiet; the media were quite clear. I saw him again in seven days, but there was no change except that some faint striæ could be seen in the lens; this gradually increased until, on March 25th, when the lens was quite opaque, with the widely dilated pupil still present; during the whole time there was absolutely no conjunctival congestion. Now why did this boy's lens get cataractous, for the slate could not by any possibility have touched the eyelids or the eye, for it was a small piece, which simply made a punctured wound three-quarters of an inch below and to the outer side of the lower eyelid? Yet he gets ptosis, paralysis of the iris, and subsequently an opaque lens. If it is thought out it will be seen that the following nerves supply the different parts affected: The levator palpebræ by the superior division of the third. The *Iris* is supplied by 12 or more nerves, which are derived from lenticular ganglion and from the nasal branch of the ophthalmic division of the fifth. *The Wound.*—The nerves likely to be implicated were the temporal or molar branches of the superior maxillary. I do not see how injury to either of these are likely to produce any effect upon the fifth or the third, and certainly no one could have prognosed that cataract would have followed such an injury.

Case 2.—W. H., æt. 60, labourer, consulted me on April 25, 1886, for loss of vision in R.E. nine months previously, was breaking stones and a chip struck the eye; thought nothing of it, but worked on, covering the injured eye; a few weeks subsequently noticed that things were double, but at last vision in that eye failed altogether; when I examined the eye I noticed that he had cataract; on more closely looking I saw a foreign body laying quietly in the lower part of the anterior chamber; my diagnosis was that the chip of stone passed through the cornea and struck the lens and then fell down into the chamber; I had no difficulty in extracting the piece of stone; I did

not think it necessary to perform iridectomy, as everything was so quiet; the cocaine had dilated the pupil, and as I was not quite sure that one part of the lens was fluid I thought I would needle it, which would enable me to complete the operation at the next sitting. Judge of my annoyance when he did not come again for three weeks (I did the operation at my rooms). When he did turn up the lens was all absorbed and his pupil quite clear, and on dilating it the capsule was all rolled comfortably away behind the iris when it was contracted, his vision being—Distance with, + 11 D. = $\frac{1}{15}$; reading + 13 D. = 0.8, Snellen. Though this was a case of "*vis medicatrix naturæ*" with a vengeance, I do not recommend my younger hearers to practise it. It was remarkable how quiet the foreign body had laid in the anterior chamber all those months, though there are numbers of cases on record where a foreign body has been in contact with the iris for years. I narrated one case in the *Australasian Medical Gazette* of 1887 (November) where a piece of steel laid on the iris for 10 years, which I removed without an iridectomy with result of perfect vision.

Case 3.—H. M., æt. 42, was struck in the eye by a chip of wood on June 20th, 1887; did not come to me until July 5; worked all the time; I found the eye inflamed, lens dislocated almost completely downwards and inwards, and cataractous; as there seemed a good deal of irritation I performed a iridectomy at once and took time to consider the next step; I was very careful in making as small an incision as possible in the iridectomy, and small as it was he lost a little vitreous: I therefore had to consider that if a large enough opening had to be made to extract a serious loss of vitreous might take place, therefore I determined to, if possible, complete the dislocation, really doing a couching operation; the lens was so nearly completely dislocated that I thought I might safely try it, which I did quite successfully, using two needles and lacerating the capsule as much as I could in doing it. The result was most gratifying, for the shrivelled lens and capsule are now lying quite quiet below the iris, and as he was very myopic before the accident, now, with a comparatively weak lens, he has admirable vision.

Case 4 I have to thank my friend Dr. Tilston for. A little boy, aged 8, who was last Easter struck in the eye with a piece of a percussion cap; the wound in cornea could be seen; he was brought to me on September 25, five months after the accident; the mother assured me that nothing was to be noticed in the eye until August, when it began to get white. I thought I could see a foreign body in the lens, Dr. Tilston agreeing with

me, but when doing the iridectomy I could not get hold of it, so I extracted *some* of the lens with the curette, hoping the foreign body would get rolled up in the remaining shrivelled up lens and capsule; when all had quieted down I was delighted to see the little piece of cap just the right shape and size that it should be, and caught in the edge of the lens. Both Dr. Tilston and myself were quite sure we should have it this time, but on seizing it with the forceps almost to our disappointment it was found to be a small clot of blood; the remaining lens and capsule was removed, and he soon got well, with an eye that, without any lens, can see $\frac{1}{5}$. A lesson to be learnt from this of never making too sure whether a foreign body or not is present. How the injury set up the cataract must for ever remain a mystery.

Case 5.—Some children playing, one was struck in the eye with a puff dart; the dart was drawn out carefully, and I saw the patient within half an hour of the accident; twenty-five minutes from drawing the dart out there was no blood, but the lens was *already* opaque. I will not say anything about the treatment in this case, I only mention it to exemplify how quickly opacity of lens *may* take place in some cases and how slow it is in others. There was W. H., whose lens certainly was months getting opaque, and this last case was minutes. Of course the injury was greater in W. H.

RUSSIAN INFLUENZA.

By W. V. JAKINS, L.R.C.P., &c.

RUSSIAN influenza, as seen in Melbourne— I say Russian because, running with it, there has been much common influenza, or fog fever, sometimes in the same house. The difference between the Russian and the common influenza lies chiefly in the deadly prostration of the former—deadly because no struggling against it is of any avail—and in the absence of coryza.

My first case occurred on 23rd February—the head of a large mercantile house, living in a healthy suburb with perfect sanitation—a middle aged man in robust health was suddenly taken with severe brain ache, shifting about, and rigors plainly visible; the weather was very hot; he wore heavy tweeds and had a blanket round him. The following week my second case came—a large manufacturer, with heavy European and American correspondence—the same temperature, 102°; the deadly prostration, the same brain ache; also pains from the loins to the knees, causing him to cry out; a man in perfect health,

with good sanitation, middle aged, and yet with a pulse intermitting at every third beat, next day at every fourth beat, following day regular; returned to business on fifth day, the former case on 3rd day. From this time the disease gradually became very frequent, attaining its maximum with the wet weather of three weeks ago, now diminishing with the dry weather, probably to increase again with the next rains.

In young children there has been high temperature, 103° , sleepiness, relaxed throat, irritative cough, and sometimes gastro-enteritis. In adults, severe pains in the limbs, between the shoulders, with spinal tenderness; fixed headaches in various parts, or shifting brain aches; orbital pains; sometimes syncope or intermitting pulse; occasionally torpid liver or fermenting diarrhoea, with eruptions; temperature has been so fluctuating as likely to mislead; I early discontinued taking it, as it varied from 96° to 103° .

I have found this disease neither infectious nor contagious, in fact two cases have not occurred to me in the same house, save a fortnight since, when one child took it a week after her father's recovery from a relapse. The wife of my first patient was attacked five weeks after her husband; in the week following the gardener took it. Relapses were frequent in the wet weather. This complaint has affected all classes, under all circumstances. The duration of each case has been from three to five days away from business.

165 Collins-st. E., Melbourne,

22nd April, 1890.

PROCEEDINGS OF SOCIETIES.

NEW SOUTH WALES BRANCH OF THE BRITISH MEDICAL ASSOCIATION.

THE eighty-eighth general meeting of the New South Wales Branch of the British Medical Association was held at the Royal Society's Rooms on the 11th April, at 8.15 o'clock. There were present: G. T. Hankins, Esq., in the chair; Dr. Collingwood, Hodgson, Sydney Jones, Fiaschi, Rennie, Lyden, W. J. O'Reilly, Ellis, Knaggs, Chisholm Boss, Lloyd, Worrall, Wright, Gwynne-Hughes, J. F. Hughes, and West; visitor, Dr. Goode.

Mr. HANKINS, the newly elected President, expressed his thanks for the honour that had been conferred upon him, adding that he could not do better than to promise to follow in the footsteps of his predecessor, and thereby to justify the action they had taken in electing him to the position of President of the Society.

The minutes were then read and confirmed.

CORRESPONDENCE.

THE HON. SECRETARY (Dr. Worrall) read a circular from the Hon. Secretary of the Annual Meeting of the British Medical Association, to be held at Birmingham

in July next, and asking that a delegate be appointed to represent the New South Wales Branch.

THE PRESIDENT remarked that it would be a good plan for any member going home to communicate with the Secretary of the Branch.

Dr. COLLINGWOOD exhibited a peculiar case of varicosity, the patient being examined by the members.

Dr. COLLINGWOOD said that the case came under his notice lately, and was one containing many interesting features. The patient was affected with varicosity, the parts involved confining themselves to the one arm. One of the chief features of the disease was that it was of long standing, the patient (a girl of about 16 years), having been affected since she was two years of age. The enlargement of the glands was noticed at a very early date. He expressed a desire that some of the members should offer some suggestions upon methods of treatment. It would not take much to cause ulceration or hæmorrhage, and the girl's parents were anxious something should be done.

Dr. FIASCHI stated that he had met with a somewhat analogous case about two years ago. A young blacksmith, warmed by his successes in aquatics, had given himself up to rowing. Unfortunately, from his birth he had been suffering from varicosity. His skin had a reddish appearance. In training his veins became exceedingly large, occasioned a great deal of interference in his movements, and checked his sculling power. Subsequently, however, he subjected his patient to bandaging; excision was resorted to, and the patient got well. In the present case under notice, however, he did not see any reason for interference as it occurred in an upper limb.

Dr. COLLINGWOOD said his idea was that there did exist a certain amount of reason for interference inasmuch as some of the veins were becoming considerably thin. Hæmorrhage might possibly result and become serious. He had a floating idea that it would be proper to ablate the veins one could not dissect, like Dr. Fiaschi did in his case. If the flow from the extremity to the centre were intercepted, probably those veins situated more proximally would reduce or contract themselves. Apart from the patient's own desire he felt inclined to interfere owing to the risk of hæmorrhage and the unsightliness of the disease, which would probably show in the neck if not interfered with.

Dr. SYDNEY JONES had seen a parallel case which was admitted to the Sydney Hospital many years ago. This occurred before the introduction of antiseptics, and no operation was thought to be safe. The patient (a man) was affected in the legs, the veins being in a similar state to those in the arm of the girl. He thought there could be no doubt that the girl was suffering from a naevoid condition of the superficial veins, and that this condition was congenital. The fact that fresh parts had become affected did not militate this view, for, as is well known in the ordinary naevus of children, vessels become enlarged and visible which were not so at birth. He agreed with Dr. Collingwood that interference was called for. In some parts the veins were very thin indeed, and ere long they would ulcerate, and hæmorrhage take place. If the disease were attacked in parts it might be done without risk.

Dr. GOODE remarked that the case was a very interesting one, and he quite agreed with Dr. Collingwood and Jones that something should be done, otherwise these veins would ulcerate and give way, with the attendant consequence of hæmorrhage. It was evident that a change was going on which might lead to ulceration. Any slight injury might cause puncture or breaking down the walls of the veins. He thought

that the plan suggested by Dr. Collingwood might be given a trial, beginning at the most distant points of varicosity and proceeding by a series of operations. He certainly thought it likely to be attended with some danger to the patient if not attended to.

The PRESIDENT said the question seemed to turn upon whether the disease was increasing. As Dr. Collingwood had stated that the disease was increasing, he (the President) certainly thought something should be done to stop it. There appeared to be a majority of members in favour of operating upon the arm.

Dr. HODGSON read notes on a case of "Closure of the Uterine Outlet after removal of Cervix for Carcinoma."

COMPLETE CLOSURE OF THE UTERINE OUTLET AFTER REMOVAL OF CERVIX FOR CARCINOMA.—ITS SEQUEL.

READ BEFORE THE N. S. WALES BRANCH B.M.A.

By R. HODGSON, L.R.C.P. LOND., M.R.C.S. ET L.S.A.

Family History.—The patient's mother died at the age of 52, of mammary scirrhus. Two operations were undertaken for its removal, but it re-appeared almost immediately after excision.

History.—Mrs. X—, aged 44, mother of six healthy children, consulted me on the 24th February, 1888, for rapidly increasing weakness which, during the last three months, had progressed at such a rate that it was with difficulty she could walk a quarter of a mile at the time she sought my assistance. Her husband had occupied a comfortable, or even affluent, position in life till a year previously when, through climatic disaster, which unfortunately overtakes so many station holders in the colony, the family were reduced to dependence on the generosity of their friends. She had always good health, but lately became emaciated. The generative system had never suffered, and regular menstruation had ceased for some months, but in lieu thereof a slight sanguineous intermittent discharge had occasionally been manifest. Physical examination did not detect any departure from the normal in viscera subjected to investigation, and her case had to rest at that point for a time as she exhibited some reluctance to vaginal scrutiny. As is usual in the majority of cases of amenorrhœa about this epoch of life the patient deemed digression to be due to physiological menopause, and hardly thought a pathological evolution might be the primary cause of her complaint. She was ordered ergota et strychnia. Three days later, being hardly at all improved, the pelvic contents were explored with this result:—the vagina was normal, but the anterior aspect of the cervix

uteri exhibited a large efflorescent ulcer, the uterus was fixed and the adjacent tissues indurated. I removed fragments of the lesion, and having stained them, the microscope revealed a profusion of nests of epithelioid cells.

On March 5, 1888, Dr. Chambers was good enough to see Mrs. X— with me, and confirmed the diagnosis of carcinoma.

Operation.—7th March, 1888. With the assistance of Dr. Deck and Dr. Drummond I amputated the cervix and followed the growth as far as possible into the uterine cavity by a V shaped incision. Moreover I felt justified in the free use of a curette to sacrifice as much tissue as possible.

Convalescence.—The patient's convalescence was unmarked by any special condition. The secretions from the wound remained intensely foetid and quite black under carbolic acid dressings, but became deodorized and decolorized by substituting an irrigating fluid of mercuric perchloride of the strength of 1 in 2,000. By this change the flux was rendered tolerable during the process of dressing.

23rd May, 1888.—There still remained a suspicious-looking unhealed surface, and I feared that some unfavourable prognostications which had wafted themselves to the patient's ken before operation would be in serious danger of verification. I therefore applied the actual cautery at intervals of about a week for some months.

20th June, 1888.—Catamenia appeared with every normal indication.

30th June, 1888.—A slight hæmorrhage showed itself for two days. This was succeeded by a quiescent interval of eleven days, when a further loss of blood ensued, lasting as its predecessor had done for about 48 hours.

My subsequent notes of the case are somewhat curtailed, as I had no idea during its course that any event would follow to render them of more than passing value. Nevertheless, on the 27th December, 1888, the word "*perfect*" was written against Mrs. X—'s name, and hence I am sure on that day, which was over nine months after excision, the parts in question were to all appearances perfectly natural. There was a small aperture leading into the uterus surrounded by healthy mucous membrane.

Between the 27th December, 1888, and the 11th May, 1889, however, the menses had become scanty, and occasionally a little pain was felt diffused over the pelvis. At first no distension of the uterus could be diagnosed, yet gradually the uterine meatus seemed to project and its walls bulge forward. The aperture looked somewhat more contracted. This semblance eventually became more marked, and the passage of a fair-

sized probe discovered a slight resistance in the meatus. When the probe was withdrawn nearly an ounce of dark grumous-looking blood immediately followed. This evacuation removed all discomfort from the pelvis till the 11th May, 1889.

25th May, 1889.—Mrs. X—— complained that for a fortnight there had been daily trifling menstrual flow which varied in amount in proportion to pain preceding its expulsion from the uterus. Occupying the position of the uterus I thought I could detect a fulness. I was unable to pass even the finest probe, and the parts were too sensitive to allow me to continue manipulations. She was therefore ordered 20 grains of antipyrin, which gave complete relief to the symptoms, and feeling quite well she left Croydon to reside in the country. The catamenia grew less and less until the middle of October, when it ceased altogether. Mrs. X—— continued to experience pelvic pains at varying intervals, and she had recourse to repeated doses of antipyrin which removed distress at the time.

The attacks occasionally assumed so severe a type that the patient could not rise from her bed, and paroxysms of asthma, which had not been present for many years, again made their appearance.

2nd December, 1889.—Mrs. X—— wrote saying she felt a rounded tumour in the hypogastrium, which reminded her of the post-partum uterus.

After serious and mature reflection I decided to ask her to come to Croydon with a view to submit to surgical interference if the inference I had drawn—that the tumour was a uterus distended by retained menses—received confirmation from physical examination. I was extremely loath to advise this measure for two reasons: Firstly, as already stated, the patient's financial circumstances had suffered much reverse, and even a minimum expenditure should not be suggested without good warrant; and secondly, one could hardly guarantee that a second operation would be crowned with as happy an issue as the first had been, and more harm than good might result from remedial manipulations. Still the alternate expectant treatment had been fairly tried and was not satisfactory.

Therefore, on the 6th December, 1889, Mrs. X—— did visit me and I found she had increased two pounds in weight. The various organs of the body were healthy with the exception of the uterus. Bimanually this was determined as a fairly moveable, hard, globular mass about four inches in diameter. Per vaginam no opening could be detected, the mucous membrane being perfectly smooth and glossy. The patient declined to seek a second opinion.

8th December, 1889.—*Operation.*—The patient was anæsthetized, and Dr. Gwynne Hughes and Dr. Jones, of Balmain, who kindly assisted me at the operation, came to the same diagnostic conclusions as I had done. Futile endeavours were made to find the former meatus. Consequently, having firmly held the uterus by hypogastric pressure, a large-sized trochar and canula was driven into the tumour, and during passage gave the feeling of penetrating resistant fibrous tissues. About five ounces of odourless, coagulable, black, syrupy fluid was evacuated, which, under the microscope, exhibited disintegrated corpuscles, black pigment granules and spherical cells floating in a slightly-yellow-tinted fluid. There were no cells larger than leucocytes, and no cells which could be construed as emanating from columnar epithelium.

The aperture made by the trochar was enlarged antero-posteriorly to about one inch. A sound recorded a depth of four inches. After irrigating the uterus a bent glass drainage tube and plug were placed in the wound. Each day the uterus was carefully syringed out with sublimate water 1 in 3,000. The temperature remained about 99°.

14th December, 1889.—Temperature 100°; marked pain during irrigation and for some hours afterwards. The syringing continued to be painful till 18th December, 1889, when the patient vomited. Temperature 101°; abdomen hard and swollen. The mercuric solution was then discarded and Pear's soap and water substituted with immediate cessation of pain, which did not again appear, and the temperature underwent a gradual fall.

20th December, 1889.—A small pelvic cellulitic effusion can be diagnosed.

23rd December, 1889.—Temperature normal, and progressing satisfactorily. Uterus $3\frac{1}{2}$ inches deep.

Reverting to the 18th: Believing that the sublimate water was causing irritation, and that it was not due to sepsis, this germicide was relinquished and no other antiseptic ever resumed. Indeed the sole reason why sublimate was employed arose from its great benefit at the first operation; but I am not at all sure it was of service at the second.

14th January, 1890.—The wound has healed some time, and there being no likelihood of danger accruing Mrs. X—— left for the country. The uterus measured $2\frac{1}{2}$ inches inside. She was then wearing a glass tube to maintain the patency of the opening.

20th January, 1890.—The tube was dislodged, and Mrs. X—— not fully realizing the importance of early reposition, delayed till the 25th January ere she visited me. It was impossible to replace

it as the canal was too contracted, although recourse was had to a steel uterine dilator.

27th January, 1890.—A smaller glass tube had to be inserted, which Mrs. X—— continues to wear.

Remarks.—The etiology of cancer is very obscure, but this case tends to corroborate a statement made by Sir Astley Cooper in his lectures on surgery, and which I have often been enabled to confirm, that carcinomatous growths frequently are noticed sequent to long mental anxiety or physical depression, and there can be but little doubt that worry, anxiety, and continued mental solicitude are potent predisposing factors. It would be interesting to learn if amenorrhœa in similar cases be really due to the menopause, or whether, as in phthisis, catamenial rest be but a localized symptom of constitutional fault. Certainly Mrs. X——'s case indicates cancer as a cause of amenorrhœa.

Nearly three months after the primary application of the knife there existed a disposition to recurrence of the neoplasm; but the cautery seems so far to have eradicated the tendency that after nine months the parts were practically normal. It is peculiar that complete closure of the uterine outlet should ensue in spite of and against a great internal pressure from retained catamenial flux. It may be pertinently asked how far, if at all, the cautery tended to induce closure of the uterus? And further, when the glass tube is abstracted need it be feared that a similar untoward circumstance will recur? It must be remembered that an opening an inch in diameter was made through the uterine wall, and that the best means to maintain patency were adopted, yet it is now only possible to insert a glass about the size of a penholder. A few weeks ago a case was briefly recorded in the *British Medical Journal* of gestation following removal of cervix, and subsequently the outlet closed completely. Extirpation of the gravid uterus was performed—with recovery. No details of the primary operation, which can be used for analogy with this case, are mentioned.

Germicides.—The case likewise furnishes subject for conjecture how far liability to cellulitis is promoted by the use of sublimate injections. Although the drainage was perfect they caused slight pain, and one might be led to believe could do harm in injudicious hands. It is admitted by Sir Joseph Lister that a great drawback to their use lies in their irritating properties, and his recent researches are directed with a view to ameliorate or exclude this drawback. During the height of germicide fashion, when the odour of carbolic acid pervaded from St. Bartholomew's almost across to Smithfield Market, I remember Sir William

Savory rather discountenanced their use on the score of irritation to the tissues, and he exhorted the students to be careful in their application. At that time the class thought he was slightly behind the age, but those students who have since entered on much practice would probably readily admit his admonitions were wise, and that the master mind foresaw many evils likely to follow implicit credulity in the beneficent efficacy of toxic germicides.

Mercuric perchloride in particular causes coagulation of albuminous particles into glutenous pellets, and these enclose bacterial spores which are again liberated when the pellets dissolve in serous exudation which is only a matter of time, for experiments demonstrate that the albuminate of mercury formed is soluble in blood serum. Besides, the pellets adhere tenaciously to roughened surfaces and require continued irrigation to effect their removal. It seems to me, therefore, that cleansing wounds should be first performed with substances which do not possess such disadvantages, and probably of these soap and water is as serviceable and reliable as anything. It softens and emollifies the secretions and allows them to be floated out in the menstrua. Following that procedure syringing or irrigating with a germicide would be unattended with one disadvantage.

He said there were one or two points on which he would feel obliged to receive advice from members, especially upon the expediency of removing the glass tube which had been inserted since December, causing much inconvenience to the patient, who had to go about her household duties. If, however, it was withdrawn, it might result in complete closure.

The PRESIDENT said the question opened a wide field for discussion, particularly as to the diagnosis and the long period that had elapsed without any recurrence.

Dr. WORRELL remarked that the result of this treatment should not cause surprise, as we knew that all caustics, including actual cautery, caused a slough more or less deep and subsequent contraction. In this case the repeated application of cautery caused such destruction that there was nothing left but a mass of cicatricial tissue, which was bound to contract. Perhaps Dr. Hodgson could not have avoided this. The uterus appeared to be so fixed that extirpation in the ordinary way was impossible. He (Dr. Worrall) had had several cases in which the uterus was so fixed that extirpation was out of the question, though he had been enabled to prolong life and give the patient a fair measure of health by curetting. To preserve the patency in this case he suggested the loop of silver wire which he had devised for Emmett's operation.

Dr. CRAIG referred to the danger of the use of perchloride of mercury in irrigating the uterine cavity, and mentioned—on the authority of the President of one of the Obstetrical Societies of America—that Dr. Garrigues knew of more than twenty deaths caused by its use in irrigating the uterine cavity after labour, see *American Journal of Obstetrics*, &c., Feb., 1890. In Dr. Hodgson's

case the patient was emaciated in the early stage, but this was not always the case in uterine cancer, as in a case at present under his own care, although the disease was in a very advanced stage, the patient had scarcely emaciated at all.

Dr. FIASCHI remarked that Dr. Hodgson's paper opened the way to discussion on many points, but he should confine himself to one or two. In the case of any circular tube lined with mucous membrane, if the whole circumference of the membrane is destroyed, fibrous tissue is substituted, and stricture follows. He referred to the patient suffering from malignant disease, and stated that he considered the use of some tube necessary, but not one composed of glass, which was dangerous, but would recommend a vulcanite tube.

The PRESIDENT said that as a pathologist was present he would like his opinion as to whether a correct diagnosis could be arrived at by merely scraping the parts and placing them under a microscope. If the disease was malignant it was a most encouraging case, as evidencing an unusual instance of cure.

Dr. WORRELL said he would like to mention a case similar to the one under discussion. Dr. Cox removed the cervix for cancer twelve years ago, and it would be an important matter to have had the opinion of a microscopist as to whether it really was cancer. He removed it by galvanic cautery. The patient, who was a young woman, has never been able to menstruate properly since; but about every three or four months discharges per rectum. For about one month in every three she is incapacitated from work. He endeavoured to do something by lifting up the bladder with a sound, but found it impossible to get into the uterus without puncturing the bladder. There appeared to be no means of relief in this case except by removal of the ovaries. The case clearly demonstrated how unscientific the electrical cautery is, and how much better and cleaner it is to use the knife.

Dr. KENNIE: As to the diagnosis of cancer of this nature, I think that no mere scraping of the surface is sufficient to found a diagnosis upon; the only satisfactory way is to remove part of the growth. If the disease was not cancer, what was it?

Dr. HODGSON thanked the members for their remarks, and would have liked some advice about leaving the tube in the patient. He did not like to take it out because the hole might close, and if it did the operation might have to be gone through again. He did not want to remove the tube if he could safely leave it in a month or two longer. With regard to fat in cancer, or persons maintaining their flesh, it did not follow that there was always emaciation. In his case, however, the patient fell away. It was with difficulty that she could walk to his house, though, when practically well, she could walk three miles. The case seemed to have been one of malignant growth. He did not scrape away the pieces, but cut off a piece and put it under the microscope. There was a little hæmorrhage, but not much. Having made a careful examination after the operation, he came to the conclusion that the case was one of cancer. Dr. Chambers had also expressed a similar opinion. Dr. Hodgson had operated in the case by consent of the patient's friends, to whom he had explained the risk of the operation, which, however, they elected to have performed.

Dr. ELLIS read a paper "On the use of Concentrated Solution of Corrosive Sublimate, and the Abortion of Syphilis." In his introductory remarks he stated that he desired to direct the attention of the profession to the subject treated, which was based upon purely theoretical argument. Having concluded the reading of the paper, he referred to a young man who came to

his rooms for treatment for a bad heart. He examined the heart, however, and found it sound. He subsequently discovered that the patient had fallen down a step-ladder, and injured the seventh rib. He could not sleep on that particular side, and woke in the morning with a headache. There was a slight indentation in this rib. He examined the patient's pulse, which gave one big bounding throb, and then stopped. The case requiring rapid treatment, he administered hyp. of æth. The patient that day had pericarditis, and was very bad, inflammation, later on, occurring in the region where the hypodermic had been given. The part was rubbed with the corrosive sublimate, and within twenty-four hours the patient received great relief. The treatment was continued for ten days. He explained that there was a cavity left in the muscle as big as a thumb.

The PRESIDENT said that the paper was one of such interest that he hoped that it would give rise to discussion. It was a question whether the application of the corrosive sublimate, when mixed with vaseline, produced blisters, or whether the absorption of the vaseline nullified this action. The effect of corrosive sublimate might, to the initial lesion, do away with secondary symptoms, but tertiary symptoms might occur in due course.

Dr. ELLIS: There was no blister formed, only a little redness of the skin.

Dr. FIASCHI's opinion was that Dr. Ellis had promulgated the theory of a new disease and a new treatment. Although he (Dr. Fiaschi) was not so sanguine as Dr. Ellis to accept this as the last discovery, he had no doubt that the paper would be productive of much good, leaving apart the new disease, on which he was not prepared to express an opinion. He agreed with Dr. Ellis that it was important to take immediate action in the case of syphilis, treating the disease along the channels of infection. According to experience, if local treatment were applied along the course of the channels, the disease would run a milder course. It was always his practice to apply mercurial treatment along the course of the seat of the chancre.

ALTERATION OF RULE IV.

Dr. ELLIS proposed "that rule be altered as follows: 4. The Council shall consist of ten members, who shall be elected from amongst the members annually, by ballot, and be eligible for re-election. From the ten Councillors the members will then select their President, Vice-President, Hon. Secretary and Hon. Treasurer; and the Executive Government of the Branch shall be conducted by such President, Vice-President, Hon. Secretary and Hon. Treasurer, and the six remaining ordinary members."

Dr. FIASCHI seconded the resolution *pro forma*.

Dr. SYDNEY JONES moved as an amendment the omission of all the words after the word "members" in the sixth line.

Dr. CRAGO seconded the amendment, which was carried.

Dr. WORRELL moved that the rule as altered stand as Rule 4 in the By-laws.

Seconded by Dr. CRAGO.

Dr. O'REILLY moved an amendment which lapsed, and Dr. ELLIS moved that a sub-committee, consisting of the President, Dr. W. J. O'Reilly and the mover, be appointed to deal with the matter and report to the next meeting of the Branch.

Seconded by Dr. CRAGO and carried.

Dr. WORRELL moved that tenders be invited from persons willing to act as shorthand reporter for the Branch.

Seconded by Dr. FIASCHI and carried.

**SOUTH AUSTRALIAN BRANCH OF THE
BRITISH MEDICAL ASSOCIATION.**

MEETING held at the Adelaide Hospital, on May 1 (postponed from April 24). Present:—Dr. Cleland (President), in the chair; Drs. P. M. Wood, Perks, T. K. Hamilton, Lendon, Lynch, Gregerson, Symons, Marten, Professor Watson, and the Hon. Sec.

Dr. LESCHEN was present as a visitor.

Dr. T. K. HAMILTON exhibited a number of patients on whom he had performed various flap operations for entropion and ulcer of the cornea. Dr. POULTON showed a case of multiple enchondromata.

The minutes of the previous meeting were read and confirmed.

Dr. T. K. HAMILTON read a paper on operations on the eyelid and eyeball by transplantation of flaps, which will appear in our next issue.

The Hon. Secretary read for Dr. MARTEN, in his absence, notes of a case of Congenital Malformation of the oesophagus, as follows:—

A CASE OF CONGENITAL MALFORMATION OF THE OESOPHAGUS, CAUSING ABSOLUTE INABILITY TO SWALLOW SOLIDS, AND, AT TIMES, LIQUIDS.

By R. HUMPHREY MARTEN, M.B., Ch.B. (CANTAB.), M.R.C.S., &c., ASSISTANT SURGEON
ADELAIDE HOSPITAL.

THE case which I am bringing before you is, as far as I can find, unique, and allows of much speculation as to the exact cause of all the trouble.

The history is as follows:—A baby, now aged 18 months, born at full term, and to all outward appearance very healthy, well nourished, and of healthy parents; but owing to the mother never having much milk, she was brought up from birth on the bottle. All went well till fourteen days old, then had an attack of "thrush," and then, for the first time, it was noticed that after three or four sucks at the bottle, the food would regurgitate through the mouth and nose; this set up laryngitis, which was followed by tracheitis and bronchitis from which the child nearly died; during this illness the baby was fed entirely on beef juice. Nothing was thought of the above attack and child kept well, except for a slight attack of bronchitis, till nearly 12 months old. During this time the mother always noticed that if by any chance the child got anything solid into its mouth, such as a piece of paper or blade of grass, that after 12 or 24 hours' incessant choking this would be coughed up again, followed by the usual lung trouble and regurgitation of food; the attacks lasting about eight or ten days.

On October 21, 1889, I made the following note: Baby has been growing very well lately, and has always been able to swallow liquid food, but never anything solid, such as bread crumbs, as an ordinary child of 12 months should do, without an attack of choking which would last for hours. The mother, who is a very observant woman, drew my attention about this time to the length of time it required the little patient to swallow the ordinary contents of a feeding bottle, and that patient would sometimes retch, but never vomit like an ordinary baby.

October 22—Yesterday, happened to swallow a piece of gravel, and has been choking ever since; tongue has become thickly coated with a white fur which always occurs when the attacks come on. Baby is extremely eager for food and cries out whenever she sees a bottle or a cup, and takes liquids ravenously, but after three or four draws or teaspoonfuls always suddenly regurgitates it.

October 23—Still the same; nurse managed to fish up piece of gravel which had been causing so much trouble for two days; this was about the size of a pea. Tongue still thickly coated and all food is regurgitated, patient is becoming exhausted and rapidly losing flesh.

October 24—Swallowing as badly as ever, much thinner and weaker. Fed on nutrient enemata every two hours.

On October 25 I got Dr. Gardner to come and see the patient with me, and he agreed with me that there must be some congenital malformation about the throat, and suggested anæsthetising patient, which we did the next morning.

October 26—Has swallowed nothing for five days, and is extremely weak and emaciated; put under ether at 9.30 a.m., and finger passed readily down to cricoid cartilage; below this a dilated egg-shaped cavity could be made out but no exit below, and all attempts to find any opening with the smallest catheter or bougie signally failed—all instruments and our fingers came up covered with a thick white fur; child soon came to and began at once to crave for food. After our manipulations patient certainly swallowed some beef juice, and appeared none the worse for the ether.

In the evening it was noted that patient had improved all day, and could swallow almost as well as before the ante-obstruction came on.

On November 28—Had another attack, and, during a choking fit in the evening, coughed up some cheesy-looking material which proved, on microscopical examination, to be sebaceous matter; could swallow liquids well afterwards. Had another attack on December 1st which lasted ten days, during which time nothing was swallowed, and patient was kept alive by nutrient enemata:

this one also ended by coughing up the same sebaceous matter. After this attack patient got quite well and strong, except that although 18 months old nothing solid has ever passed below the obstruction, and patient has now gone to seek the best European advice on the obscure condition; and although I have not yet heard from her home practitioner, I hear from the mother the patient keeps well and strong, and continues to grow.

From the history and physical examination of this case I think there can be little doubt that the symptoms are caused by a narrowing of the gullet below the cricoid cartilage, with the usual dilatation above the narrowing. The difficulty is to explain the causation of this narrowing, and also to give a prognosis, determine what surgical treatment, if any, should be adopted.

Two varieties of dilatation pouch are described in the oesophagus, one due to a giving way of the mucous membrane at the junction of the pharynx and oesophagus, which leads to a pouch forming, and towards the end of a meal this becomes filled with food and compresses the gullet and so prevents further deglutition until emptied; and the second variety is due to traction from an inflamed gland contracting and drawing on the walls of the oesophagus, so thus forming a pouch, but neither of these account for the conditions found in my patient. It was always noted so long as the tongue remained clear the baby could swallow fluids with ease, but if anything irritated the pouch, such as the piece of gravel above mentioned, or the attack of thrush which was the first to call our attention to the trouble, the swallowing at once became impossible.

I think this points clearly to the fact that an opening of a small size exists, but on the furring of the tongue, and with this the oesophagus, it is closed up and only becomes free on the fur clearing away.

When first attempting to account for the condition present I thought we might be dealing with an imperforate stomodeum, similar to the proctideum which causes imperforate anus and rectum, but I find from the development that the stomodeum only goes back to the pharynx, and the condition in my patient's case was below the cricoid cartilage and so well below the upper end of pharynx.

Again congenital dermoid cysts are found in the neck connected with the remains of the bronchial clefts; now on several occasions my patient coughed up sebaceous matters and then could immediately swallow—it occurred to me that the lowest bronchial cleft might have caused such a condition, and the cyst communicate with the oesophagus, and when distended compress the

tube. Of course this is only a theory, but I think it worth considering. I would be very glad to hear of any other opinions as the causation of this peculiar condition from any member present.

With regard to prognosis in such a case, I should imagine it is fairly good, for as the stricture in the oesophagus is non-cicatricial there is no reason why, as the other portions of the gullet enlarge, this opening should not also grow.

The treatment up to now has simply been tiding the patient over the acute attack, as it was found impossible to pass any instruments from above with a view of dilating the opening. We suggested to the parents when the child appeared in extremis to open the stomach and attempt a Loretto's operation from the cardiac end, or an alternative was to open the dilated portion of the tube, as in oesophagotomy, and attempt to find an exit and so dilate it. But the child's rapid improvement after coughing up the sebaceous matter prevented any operative interference.

Dr. POULTON read the following notes on two cases of Hydatid of the Liver, and showed some pathological exhibits.

TWO CASES OF HYDATID OF LIVER.

By B. POULTON, M.D. ET CH.B., M.R.C.S.E.,
HON. SURGEON ADELAIDE HOSPITAL.

Case I.—Ch. D., æt. 53, bushman, seventeen years in country; admitted Jan. 18, 1889; discharged, cured, April 2, 1889. A month ago went into the Kapunda Hospital for a stoppage of the bowels, which was accompanied by swelling of the belly; was relieved by enemata; had been quite well up to that time and always able to do his work as cook on a sheep station; had syphilis eight years ago.

Jan. 19.—There is a prominent rounded swelling of the right side of the abdomen, extending downwards to the level of the umbilicus; it feels smooth and tense and is dull to percussion: the area of dullness merging above with that of the liver; there is no hydatid fremitus; a hypodermic needle inserted draws off clear, colourless fluid, in which no scolices were found under the microscope; temperature normal; slight cough.

Jan. 20.—Vomited at midday yesterday; temperature 102; cough troublesome; slight dullness on percussion of a small area about the middle of the posterior border of the right scapula; an occasional rhonchus near the lower angle of the right scapula (Broncho-pneumonia); a trace of albumen in his strongly alkaline urine, which is loaded with triple phosphates; the second sound

of the heart accentuated at the aortic area ; the arteries of the forearms atheromatous and tortuous.

Jan. 23.—Fine crepitation at base of each lung, but the temperature being now normal abdominal section was made under ether ; the sac was stitched to the parietal peritoneum and parietes (except the integument) and then opened by incision ; after secure fixing by further silk sutures the cyst (one large single cyst) was removed with its clear fluid contents ; one large and one small drainage tube were inserted, and, after thorough irrigation, a gauze and wool dressing was applied.

For a week after the operation the temperature vacillated between 98 and 101° and the patient was subject to a low form of pneumonia, which did not fortunately become general ; the discharge from wound bile-stained and aseptic.

Jan. 29.—Temperature normal ; cavity contracting ; tubes removed ; a plug of gauze placed in wound ; put on quinine.

The wound healed but slowly, and was dressed henceforth with carbolic oil and then with elemi ointment.

Discharged well on April 1, there being still a small sinus. The sutures were removed during the first week : one which was overlooked did not separate until April 5, after which the sinus closed rapidly.

It will be noted that the presence of Broncho-pneumonia at the time of operation did not militate against the satisfactory progress of this case.

Case II.—W. O'C., æt. 25, station hand, born in South Australia, lives at Meningie, on the Murray ; admitted May 10, 1889 ; discharged January 9 ; complains of a lump in the left side which he never noticed before last Sunday, five days ago, when he had great pains in the side. There is a prominent rounded tumour in the region of the stomach, situate chiefly to the right of the mid-line and immediately below the costal cartilages. It feels about the size of the foetal head, moves with respiration but cannot be moved laterally. Its dull percussion note is continuous with that of the liver, and merges into the area of cardiac dulness. The lung and heart sounds are normal ; the urine is normal ; the temperature is 101·4 deg.

The aspirating needle inserted and a little cloudy fluid withdrawn, showing pus cells and hooklets under the microscope.

The tumour being most prominent to the left of the middle line I cut down upon it then. The sac had contracted parietal adhesions. After suturing the sac to the abdominal wall for greater safety it was opened, and a suppurating multiple hydatid with its daughter cysts removed by irrigation and the forceps. Notwithstanding very

free irrigation, which was continued daily, small cysts were washed away occasionally during the next two months ; the cavity showed great obstinacy in closing, and was scraped out with a sharp spoon. In September the cicatrix was laid freely open and five small collapsed cysts removed ; the sides of the cavity, extending several inches upwards and to the right, were scraped freely and diligently washed out ; the cut edges were sutured to the abdominal wall. After this second operation small cysts were occasionally washed out in dressing ; the patient suffered much from vomiting, pain and pyrexia, and the cavity showed no sign of closing in November. The lungs were normal, there was no increase of hepatic or splenic dulness ; no albumen in the urine ; the pulse was full, strong and regular, the temperature normal.

On November 16, under ether, and assisted by Dr. Gardner, I enlarged the sinus upwards and passed a probe right across into the right lobe of the liver, then passing the index finger in as far as it would reach, I cut through the abdominal wall on to the spot where the tip of the finger pressed the liver substance upwards, stitched the liver to the parietes with tendon, and having thus shut off the peritoneal cavity, cut through the liver on to the finger tip and drew a full sized tube right through both openings—cavity stuffed with gauze. No cysts were found.

This operation was followed by pyrexia, troublesome vomiting, and in December he had a sharp attack of pneumonia of the right lung. The cavity, however, gradually contracted and he was sent to the convalescent hospital on January 9, 1890, with a small sinus at the site of the first incision, the other having closed.

The man reported himself in March fat, strong and quite well.

I have ventured to report this case as an instance of the very great difficulty which may be experienced in evacuating early and completely all the contents of an hydatid sac, notwithstanding free incision and careful prolonged irrigation. Two incisions primarily would probably have secured a more speedy termination of this case, the delay in healing having been caused by the retention of small daughter cysts. The small sinus which persisted so long in the first case was due to, now, absorption of a silk suture. I have of late used only kangaroo tendon sutures, which are quite sufficiently strong, retain their integrity for 7 to 10 days and do not cut through the tissues.

STYLOGRAPHIC PENS, in Vulcanite, with dropper, in card-board box, complete. Price, 6s. ; postage paid to all parts. L. Bruck, Importer, Sydney.

THE WESTERN MEDICAL ASSOCIATION OF SYDNEY.

A Medical Association for literary, defensive and social purposes has been formed in the western suburbs of Sydney.

A meeting was first held at Dr. MacSwinney's residence, Petersham, on April 3rd. All the medical men practising in Petersham and immediate districts were present except one. After discussion it was decided that the whole of the medical men residing in the western suburbs, from Newtown to Parramatta, be asked to attend a meeting for the purpose of considering the desirableness of forming an association. This meeting was held at Dr. Collingwood's house on April 5th, when medical men from Newtown, Petersham, Leichhardt, Marrickville, Summerhill, Ashfield, Croydon, Burwood, Auburn and Parramatta were present.

It was decided to form an association, and a number of gentlemen were nominated for the different offices.

The following is the result of the ballot:—President: Dr. MacSwinney; Vice-Presidents: Dr. Collingwood and Dr. P. Sydney Jones; Treasurer: Dr. Macneill; Secretary: Dr. Coutie; Council: Drs. Traill, Thring, R. T. Jones and Service.

At a subsequent meeting held in Petersham on April 29th, the following resolution was agreed to:—

"That the minimum tenders of members of this Association for medical services to lodges from this date be as follows:

"Ordinary and Mixed Lodges.

"Medical attendance only, £1 per member per annum.

"Medical attendance with medicine, £1 8s. per member per annum.

"Women's Lodges.

"Medical attendance only, 15s. per member per annum.

"Medical attendance, with medicine, £1 1s. per member per annum.

"Confinements, £1 1s.

"That three months from this date all existing contracts under the Association's minimum standard must cease to exist, or to be raised to the standard, otherwise the contractor must cease to be a member of this Association."

It was decided to forward this resolution to the Council of the New South Wales Branch of the British Medical Association with a request that the members of the Branch be asked to decline to tender at a lower fee than the above in the western suburbs.

MEDICAL SOCIETY OF VICTORIA.

A SPECIAL meeting of the Medical Society of Victoria was held on the 16th April for the purpose of discussing the question of the abuse of hospitals and of the lodge system.

Dr. J. W. BARRETT opened the discussion by reading a paper, in which he pointed out the manner in which our hospitals and those by whom such institutions were supported were imposed upon at present by those able to obtain medical services for themselves, also the extent to which the lodge system was abused. With regard to the question, Who is to effect the change? the answer was the medical men, who ought by this time to have learnt the lesson that the trade unions have taught them. If they did not combine, the destitute would continue to be belaboured out by those who were not; the generous public would continue to pay the doctor's bill of a class

who should pay it themselves, and in doing so would continue to injure a class who could not; and medical men had themselves to thank if they permitted themselves to be swindled in the future.

The members who spoke were unanimous on the matter of the imposition on the hospitals by large numbers of well-to-do persons, and it was ultimately decided to refer the matter to a committee of the society for report.

DELIRIUM TREMENS!!!

THE REV. DR. TALMAGE, in a temperance sermon recently preached by him in New York, is credited with having gravely given utterance to the following imaginative gem:—

"Dr. Sax, of France, has recently discovered something which all drinkers ought to know. He has found out that alcohol, in every shape, whether of wine, or brandy, or beer, contains parasitic life called bacillus potumania. By a powerful microscope these living things are discovered, and when you take strong drink you take them into the stomach and then into your blood; and getting into the crimson canals of life, they go into every tissue of your body and your entire organism is taken possession of by those noxious infinitesimals. When in delirium tremens a man sees every form of reptilian life it is only these parasites of the brain in exaggerated size. It is not a hallucination that the victim is suffering from. He only sees in the room what is actually crawling and rioting in his own brain. Every time you take strong drink you swallow these maggots, and every time the imbibor of alcohol in any shape feels vertigo, or rheumatism, or nausea it is only the jubilee of these maggots."

The deliciously authoritative manner in which this celebrated preacher gives forth this very novel pathological theory as to delirium tremens is superb. He is apparently as dogmatic in matters medical as in those theological, and is positive upon as little evidence, and with as little proof in the one case as in the other.

We have always realized the necessity of imagination first, with faith afterwards, in questions of religion, but doubt the advantage of their similar application to pathology.

THE Right Honourable W. E. Gladstone on March 26 visited Guy's Hospital as Senior Governor, on the occasion of the opening of the new Medical College for resident students attached to the Medical School. In the course of an address to the company present Mr. Gladstone made the following remarks relative to the profession of medicine. Coming from a man of so much ability and experience they cannot but be viewed as highly complimentary. The testimony of course would have been more gratifying if it had been given earlier in his career, before he had astonished the world by the course of action he has adopted during recent years, when there would have been no reason to doubt the sincerity of any statement he might make. The following are the remarks referred to:—"He contemplated with singular satisfaction the independence of the medical profession. It did not rely upon endowments. There was, indeed, no great profession which had so moderately and modestly dipped its hand into the public purse. It was eminently self-supporting, and this did much to maintain its honour and independence, and enabled it to pursue its stately march, to form its own convictions, to act on its own principles, without fear or favour, for the general benefit of mankind."

NOTICE.

The Editor will feel obliged by any gentleman, who wishes to ventilate any subject of professional or public interest, writing an editorial or leading article on it, which if found on perusal to be consonant with the policy of the paper, will be inserted in an early number.

All communications intended for the Editor should be sent to the 'A. M. Gazette' Office, 35 Castle-reagh Street, Sydney.

*** Contributors can have their Papers reprinted and published in Pamphlet form, at Cost Price, if the necessary instructions are given to the Publisher at the same time the contributions are sent in.*

AUSTRALASIAN MEDICAL GAZETTE.

SYDNEY, MAY 15, 1890.

EDITORIALS.

NEWCASTLE MEDICAL SOCIETY.

A MEDICAL Society was inaugurated at Newcastle in 1886, under the presidency of Dr. C. W. Morgan, and some good work was done during the first year. From a variety of changes in the profession, the departure of several members and the illness of others the Society fell into abeyance during its second year, but a desire was always expressed that it should be resuscitated.

This at last culminated in a medical dinner held at Newcastle on the 28th December last, well attended by the profession of the district, at which it was resolved that the Society should be re-organized and re-established. During the year the profession had received many additions to its ranks, the number of registered practitioners in city and district exceeding twenty. A committee consisting of Drs. Morgan, Harris, Nash, Beeston, Bonnefin and Williamson was appointed to revise the rules of the old society and prepare a report as to the best lines on which it might be re-organized. Dr. Morgan offered his services as secretary for the first year.

The committee brought up the report and proposed new rules at a meeting of the medical profession, held at the Board-room of the Newcastle Hospital on 15th March last, at which the Society was declared reformed, the rules discussed, amended and adopted, and the following members enrolled: Drs. J. L. Beeston, F. H. Bonnefin, W. L. Eames, John Harris, J. W. Hester, V. E. Ludlow, H. C. MacDouall, W. K. MacRoberts, C. W. Morgan, W. Nickson, J. Ward, and W. C. Williamson, of Newcastle; A. W. Nash and

R. H. Treloar, of Wickham; A. Harwood, of Merewether; G. F. Smith, of Adamstown; J. J. Stapleton, of Lambton; J. B. Nash, of Wallsend; B. B. Floyer, of Minmi; and J. Meredith, of Raymond Terrace.

The meeting then proceeded to elect the following officers for the current year: President, J. B. Nash, M.D., M.R.C.S.; Vice-president, W. C. Williamson, M.D., Ch.M.; Treasurer, Dr. Hester; Hon. Secretary, Dr. C. W. Morgan; Council—Drs. Harris, Beeston, Bonnefin, Stapleton and Treloar; Auditors, Dr. Eames and MacDouall.

The first sessional meeting held on the 10th April was well attended. Dr. J. B. Nash read an able paper on enteric fever, with notes and charts of 18 cases. The discussion thereupon was postponed, as was a paper on the action of antifebrin by Dr. H. C. MacDouall, owing to the lateness of the hour. Pathological exhibits, prepared by Dr. Bonnefin and Hester, were shown and notes read explanatory of the cases to which the specimens belonged. They included:—1. Enlarged and degenerated spleen of a seaman who had suffered from the remittent fever of Java. 2. Fracture of both maleoli immediately above left ankle, with dislocation of foot backwards. 3. Extensive calcareous deposits in mediastinal glands, impinging on left bronchus, death from syncope—taken from a woman of thirty, of dissolute habits, who was found dead in a police cell in which she had been incarcerated. 4. Sections of fatty liver and heart. 5. Large encysted encephaloid sarcoma, involving anterior and external muscles of thigh, necessitating amputation at hip joint. 6. Fibroid tumour found beneath dura mater, the probable result of organized clot. In this case there were marked reflex phenomena of one side, epileptic attacks, supposed to be due to cerebral irritation occasioned by an accident, and some hemiplegia. A tumour was localized and an operation proposed, but the patient died suddenly before the time arranged for its performance. On examination the localization of the tumour was found to be correct as to detail but incorrect as to the lobe affected, the tumour being discovered on the same side as the reflex phenomena, and paralysis exactly corresponding to the position in the opposite hemisphere, where an operation had been suggested.

The Association may now be considered to be at work. Other papers are in the hands of the council, and the next meeting will take place on the 15th instant. Great hopes are entertained that in so large a field of observation as Newcastle affords, much practical and scientific work will be recorded through the medium of the Newcastle Medical Society.

DAIRIES SUPERVISION ACT OF NEW SOUTH WALES.

IN this issue appears an advertisement of the Board of Health of New South Wales, publishing the clauses of the "Dairies Supervision Act," relating to the reporting by the medical practitioner in attendance on any case of cholera, enteric fever, smallpox, scarlet fever, diphtheria, measles, or syphilis occurring upon premises licensed as a dairy or place for the sale of milk.

It is highly important in the interests of public health that the clause which requires such disease to be reported should be implicitly obeyed by medical men having cases in such places under their care, but independently of the moral obligation which they are under to do so, neglect will render them liable to a fine not exceeding £20.

The clause relating to the immediate suburbs of Sydney is somewhat obscure as to with whom the information should be lodged. It says that outside the City of Sydney the case must be reported in writing to the Clerk of Petty Sessions or Government Medical Officer, neither of whom exist in the immediate suburban districts. We think, however, that practitioners in such districts had better report direct to the Board of Health, by which means they will better fulfil the requirements of the case than by reporting to a mere police officer.

LETTERS TO THE EDITOR.

THE TREATMENT OF SNAKE-BITE.

(To the Editor of the A. M. Gazette.)

SIR,—In an article headed "A Contribution to the History of Medicine in Australia," by Dr. Mueller, of Yackandandah, Victoria, in your April number, he makes an assertion perfectly unwarrantable when he says "that no medical man in Australia now can dare to treat a case of snake-bite by any other than my method without incurring the charge of culpable ignorance or neglect in case of the patient's death." Either Dr. Mueller's memory must be very short, or he has been so much carried away by his theories in regard to the treatment of snake-poisoning that he will not admit of the possibility of any antidote other than the one he employs.

My reason for the statement I have made is as follows:—On the 17th September, 1888, R.L., æt. about 50 years, was brought to me, a distance of 12 miles, suffering from snake-bite. The man, while fencing, had been bitten by a tiger snake in the calf of the leg, on the bare flesh, and immediately after the bite he pulled up his trousers and tied a piece of string above the bite, then took a strap from his waist and strapped it firmly above the ligature. He then proceeded to the Bonegilla Park Station, upwards of a mile from where he was working, when, after a short delay, Mr. Wm. Pearson, junr., drove him in to me, about two hours

elapsing from the time he was bitten till the time I saw him, when he was in an unconscious state.

After removing the ligature and strap I injected, hypodermically, ten minims of a solution of permanganate of potassium, of the strength of nine grains to the ounce of water. For upwards of five hours he remained in this unconscious state and, as the heart showed failing action, I injected ether four separate times. At last he began to show signs of life, and by dashing cold water in his face and other means, I roused him sufficiently to get him into the open air with assistance. I then noted that his legs were almost powerless, and on trying to administer strong coffee, also beef tea, found he was unable to swallow. I then, with the assistance of kind friends supporting him on either side, walked him up and down for some hours, giving him a rest every now and again. Whenever we allowed him to sit great drowsiness overcame him, and it was not till 10 o'clock p.m. that he could articulate distinctly. I then saw him to bed, his wife watching him during the night, and in the morning he walked to Albury, a distance of three miles. No bad results followed the bite or injection, and no abscess formed. To-day the man is at his usual occupation as a selector.

In conclusion I have to state that Dr. Mueller called on me a day or two after this case to enquire if I had used the antidote he employs, when I informed him that I had not done so, but told him what I had done, at which he seemed much disappointed.

At the Medical Congress held in Melbourne in January, 1889, I told him again, in the presence of Dr. Thwaites, what I had used and that I had treated a second case, on November 12, 1888, successfully by the same method. Since then, on November 27, 1889, I had another successful case. At the Congress I mentioned to Baron von Mueller and others my mode of treatment, but I did not think two cases sufficient to bring before the meeting.

In all I have treated three cases, with good results, and these are the only cases I have seen.

I do not claim originality in the use of Pot. permang. in the treatment of snake-bite, but I am not aware that it has been used in similar doses.

My record, in the time, is better than Dr. Mueller's, and I am anxious for others to try it.

I am not one to rush into print on every slight pretext, and I would not trouble you now, but when you have given such prominence to Dr. Mueller's treatment I feel sure that you will do justice to my communication, more especially as Dr. Mueller has ignored any other treatment than the one he employs. I will not enter into any scientific hypothesis at present, as I fear I now have occupied too much of your valuable space, but merely state that I believe snake-bite to be a blood poisoning and pot. permang. an antagonistic to that blood poisoning.

I am, &c.,

JOHN HUGH MACKENZIE
F.R.C.S.E., &c.

Wodonga, Victoria,

May, 1890.

[WE think our correspondent is unwise to have challenged comparison between the methods adopted by Dr. Mueller and himself in the treatment of snake-bite.

Dr. Mueller has published a lucid and scientific exposition of his theory as to the cause of the dangerous symptoms arising from snake-poison, and the therapeutic reasons which induced him to adopt the hypodermic injection of strychnia as a true physiological antidote for them. The success of his remedy has been proved again and again by the result of its use by

various practitioners in different colonies, who stand in an entirely disinterested position with regard to it. Our correspondent expects our readers to accept him as a successful rival in this matter upon the strength of his injection of a solution containing about one-sixth of a grain of permanganate of potassium into some part of his patient—he does not tell us where; it may have been into the wound or anywhere else. He seems also to forget that this salt is so easily decomposed by contact with organic matter, that "Squire" cautions his readers from even keeping the solution in corked bottles for this reason, so that it is highly improbable that any would be left unchanged to act on the poison. We think the injection of ether had much more to do with the patient's recovery—if it was due in any way to the treatment—than the permanganate. As he gives no particulars of his remaining two cases we are not in a position to review them. He is prudent to "not claim originality" in the use of permanganate of potassium in the treatment of snake-bite, for it has been experimented with for this purpose by Sir Joseph Fayrer so long ago as 1869, and since then by Dr. Richards and Dr. Lacerda, each of whom consider it to be capable of destroying snake poison, *but only if brought into actual contact with it*. The latter gentleman has the most faith in the remedy, but he expresses some doubt as to its efficacy when the poison has reached the general circulation, even if the injection is made directly into a vein. The injection of strychnia on the contrary, should not be tried until the poison has reached the general circulation, which should be prevented if possible by excision of the bite, whilst the drug does not require to be brought into immediate contact with the snake poison to work its effect.—ED. A.M.G.]

DR. MARTEN'S CASE OF EXTRA-UTERINE FŒTATION "CURED" BY THE FARADIC CURRENT.

(To the Editor of the A. M. Gazette).

SIR.—The title of Dr. Marten's paper in your issue of this month contains a word which at once arrests attention, namely, "*cured*," used in connection with an extra-uterine foetation. This makes us study the paper with unusual attention, for it is not customary to talk of physiological processes as being "*cured*;" in the case of pregnancy, normal or abnormal, the word "*arrested*" would be nearer the mark, since bones, cartilage, brains, ligaments, muscles, and tissues of various other kinds constituting a *fœtus of fifteen weeks' duration* are not so easily "*cured*" away as Dr. Marten's paper would lead us to believe. On the contrary the bones at least remain in their place if not extracted or expelled in some manner or other, until the death of the parent, constituting in the case of normal pregnancy a case of "*missed labour*," in the case of extra-uterine foetation an irreducible tumour, larger or smaller according to the powers of absorption possessed by the patient, but always tangible. Now Dr. Marten's patient must have possessed these powers even to the point of absorbing bone, for she left for England with "*only a thickening of the left broad ligament*."

Whether this was extra-uterine foetation or not, the result has been splendid as far as dispersion of an abdominal tumour by electricity after Apostoli is concerned; but it is certainly a pity that, as Dr. Marten himself admits, all the most cardinal points necessary to establish the existence of extra-uterine foetation, according to Lawson Tait and Reeves' article, are

absent from Dr. Marten's case, and that those which he emphasizes most are the very ones upon which the authors quoted "*do not lay much stress*." There was no long continued sterility antecedent to the symptoms, there was no salpingitis and there was no discharge of a deciduum, "*which would have been of the greatest help*, and Lawson Tait, again quoted by Dr. Marten, himself once only diagnosed unruptured extra-uterine foetation, and throws doubt on those cases reported as such. I am afraid that Mr. Lawson Tait will not be encouraged to place greater reliance on the correctness of diagnosis in such cases if the arguments used by Dr. Marten to prove his case are the only ones that can be adduced. Tait, I fear, will be inclined to agree with me that a very good instance of a case of pelvic hæmatocele being mistaken for something else and "*cured*," has once again been recorded.

It was, perhaps, a very fortunate thing that under the circumstances a laparotomy was not done.

Dr. Marten says that "*he could not define the swelling from outside*," and immediately afterwards, "*that from history and symptoms he suspected an unruptured cyst*." Then why was not the tumour "*defined*" when the ether was administered at the consultation? Then as to the bruit heard, if a binaural stethoscope be introduced into any cavity of the body a *bruit* may be heard, indeed a straight stethoscope placed upon the muscles of the thumb will allow a bruit to be heard. The foetal heart, as a matter of fact, is not heard until the end of the fourth month (eighteen weeks) whilst the *uterine souffle*, which presumably is alluded to in the text as "*the bruit*," may be heard at the beginning of that month if the foetus is in the uterus, to the contractions of which it is due, according to Braxton Hicks, *being often intensified after the death of the fœtus*. "*It is generally audible in large fibroids of the uterus, &c., and is therefore of little or no value*." ("Playfair's Midwifery," 6th ed.) Dr. Marten's paper accounts for only fifteen weeks in his case, so that neither of these sounds were to be expected in an ectopic gestation of that period. The bruit therefore must have been muscular; in pelvic hæmatocele, between the layers of the broad ligament, there would be much the same coverings to the swelling that an ectopic gestation would have in that direction, hence the contractions spoken of by Dr. Marten would cause plenty of "*bruits*," even in the case of hæmatocele.

The collapse described as occurring on November 15 was exactly that which occurs in internal hæmorrhage, the appearances next day coincided also with those of an hæmatocele, as did the subsequent progress of the case, ending in complete absorption without any fistulous opening or discharge of bones.

Such a state of collapse in a genuine case of ectopic gestation would indicate rupture of the cyst most undoubtedly, but Dr. Marten wishes this to be considered as a case of *unruptured* cyst. He, therefore, cuts the ground away from under his hypothesis and drives us to the conclusion that hæmorrhage must then have occurred, as it had done before, and as the red discharge distinctly emphasized.

I do not wish to detract from the value of this observation, backed up as it is by Dr. Gardner's opinion, yet I could not help noticing that it was a case in which a mistake might have been made, especially as Playfair records that a case in which Joulin Hugnier and six or seven of the most skilled obstetricians of Paris diagnosed extra-uterine foetation and sanctioned laparotomy, terminated by absorption and proved to be a natural pregnancy.

So in the absence of evidence that the foetal bones were found or extruded I must decline to recognize this

as a case of "cured" ectopic gestation, and consider it more likely to have been a pelvic hæmatocele in which further hæmorrhage was checked by the strong faradic current used, and absorption subsequently thereby hastened.

I may be behind the times, but when I was a student it used to be one of those "canons of surgery," which Mr. Hutchinson speaks about, not to do life-endangering operations on cases recently exsanguined by hæmorrhage and, with all due respect for the opinion of Dr. Gardner, it seems to me that this was a case in which a third or fourth opinion would have assisted greatly in the diagnosis. If you, Sir, see in my remarks anything not justified by the publication of the case you will, of course, withhold them; but I see by a recent number that a paper by Dr. Ross has been criticized in your columns, and the criticism is evidently taken in very good part by that gentleman.

I am, Sir,

Sincerely yours,

F. W. ELSNER.

Richmond, Melbourne,
April, 1890.

(To the Editor of the A. M. Gazette).

THE case which Dr. Marten, of Adelaide, has published in the last number of the *A. M. G.* as "Extra-Uterine Foetation cured by the Faradic Current," should not be allowed to pass without criticism. Here is a woman about three months pregnant, who, after several minor attacks of sudden pain in the lower abdomen, is seized with such severe pain as to cause complete collapse. On examination "the uterus is found pushed to the right by a tense, tender swelling in the left broad ligament. From the history and symptoms ruptured extra-uterine foetation was suspected" and a very strong Faradic current was applied, this treatment being adopted because of its "simplicity," and because the "precarious state of the patient rendered her unsuitable for surgical interference," and yet this simple, mild treatment caused such violent struggling and opisthotonus as to require two doctors and three nurses to hold the patient down in bed!!

Dr. Marten may have reasons not mentioned in his paper for considering this a case of ruptured tubal pregnancy, but after a careful perusal of the account which he gives, it appears clear to me that the case was one of tubal pregnancy, which had ruptured (when the patient was attacked with the very severe pain) downward between the layers of the broad ligament, forming an extra peritoneal hæmatocele, and, as the great majority of these cases get quite well without active treatment, the application of a powerful Faradic current was not only unnecessary, but highly dangerous.

Let me give a short account of a similar case. Mrs. M., set 30, a professional nurse, was married on September 23, 1888. Period came on as usual on October 8, missed the period in November and December. On December 13, whilst nursing the wife of a medical man in this city, felt a sudden severe pain in lower abdomen, lasting for four hours. On the 14th and 17th was attacked in a similar way, and on the 19th occurred the "worst attack of all," causing profound collapse, anæmia and vomiting. Admitted to the Sydney Hospital on the 20th. Her condition then was as follows: Markedly anæmic, pulse 100, very weak, temperature 98. Abdomen slightly distended and tender; considerable pain lower abdomen. P. V. uterus pushed forwards and to right, moderately fixed, tender, and somewhat enlarged. The left broad ligament contained a tender, elastic body the size of a

large orange. There was a slight red discharge from the uterus, and on December 28 this became profuse and contained several large pieces of decidua. The pain and the red discharge continued more or less during the whole of January without any material alteration in the physical signs. During February her general condition steadily improved, there was distinct hardening and contraction of the mass in the left broad ligament, with disappearance of tenderness. She was discharged on February 28th. Examination on March 27 shewed that there was still a small hard mass in left fornix, but symptoms were entirely absent. She has nursed cases for me ever since and remains well, although sterile. Now, Sir, if the battery had been applied here it would have got the credit of killing a living foetus in the Fallopian tube, whereas in reality it would have exerted its power, and, to the detriment of the patient, upon a dead ovum, surrounded by blood, the result of a rupture downwards between the layers of the broad ligament, needing only rest and time to become completely absorbed.

The treatment of ectopic gestation by electricity is rapidly dying out, for the following reasons:

The cases coming under the notice of the surgeon before rupture are very rare.

If the condition should be discovered before rupture the current may cause a rupture into the peritoneal cavity and kill the patient in a few hours.

Even if it be applied with success it leaves a damaged and useless tube, likely to be a cause of trouble and suffering for many years.

Finally, ectopic gestation is so frequently complicated by other conditions, such as intra-uterine pregnancy, cysts, tumours, &c., that abdominal section, which not only accurately determines the exact condition, but allows of the treatment being altered according to circumstances, must always hold the field against a plan which works in the dark and is as likely to injure as to benefit.

I am,

Yours, &c.,

RALPH WORRALL, M.D., M.CH.,

Hon. Assistant Surgeon to the Department for Women
at the Sydney Hospital.

Hyde Park, Sydney,
April, 1890.

HOMŒOPATHY.

(To the Editor of the A. M. Gazette.)

SIR,—Having opened your columns on the subject of Homœopathy, you will of course be liberal enough to ventilate the opinions of both sides of the question of Homœopathy.

Your correspondent evidently means well, and judging from his article on Homœopathy, he possesses an amount of therapeutic knowledge more than the great majority of Allopaths do, but yet he is still quite a novice, and I have no doubt he will make a good and staunch Homœopath some day, and that with more extended experience he will regret his rash statement of imposture and charlatancy.

Homœopathy is an extremely difficult question, and I fear a full discussion on it would be deemed too lengthy for your *Gazette*. There are many thousands of standard works upon it, one of them at least, Allen's *Encyclopædia*, being in ten volumes quarto of six hundred pages each, and I would earnestly recommend this to the attention of your correspondent.

The question of the scientific correctness of Homœopathy has long since been completely thrashed out in America, and the new question now before the

American United States Legislature is whether the Licensing Medical Board is to be composed of Allopaths and Homœopaths conjointly, for which with a majority representation the Allopaths are contending, or whether the two schools are to have separate licensing boards which the Homœopaths desire. And this struggle is interesting even to us, as we probably will be doing likewise after half a century of years has passed by, so far are we behind in the march of intellect.

Your readers will be well repaid by reading the controversy on Homœopathy published in the London *Times* December 1887, and January 1888, particularly the summing up on the 20th January. A reprint from *The Times* in pamphlet form is to be had. *The Times*, which is perhaps the most influential paper in the world, said in unmistakable terms that the Homœopaths had the best of the controversy.

I shall be pleased to present any of your readers with a set of the Homœopathic league tracts published at 12 Warwick Lane, London.

The following is from *The Homœopathic World*, 1st September, 1887:—

POSITION OF HOMŒOPATHY IN THE STATES.

The institute has caused to be printed the following card, which we gladly reproduce, giving a statistical statement of the position of Homœopathy in America. This statement is issued because many erroneous ones have obtained currency. We are indebted for the card to Dr. Strong:

"Introduced into America by Dr. Gram, in 1825, a stranger in a strange land, with a strange system of medicine. In sixty-two (62) years it has grown as follows in the United States:

Practitioners ...	...	11,000
Medical Colleges ...	...	14
Matriculates Annually ...	...	1,200
Graduates Annually ...	...	400
Hospitals (with 4,500 beds)		
Mortality, 1.5 %	...	57
Insane Asylums ...	...	3
Dispensaries...	...	48
Societies ...	...	150
Journals ...	...	23
Pharmacies ...	...	33
College of Specialties ...	...	1

"Thirty-four dispensaries report for one year, 1886, 142,629 patients provided for with 376,886 prescriptions.

"The oldest national medical association in this country is homœopathic—The American Institute of Homœopathy.

"Homœopathy is employed chiefly by the more cultivated portions of communities. Homœopaths can procure lower rates of life insurance on account of the lower rate of mortality among them, as proved by statistics.

"Alumni Homœopathic Colleges, 7,732.

"First Homœopathic College, 1848."

In 1889 the Melbourne Homœopathic Hospital treated 408 cases of typhoid fever, with a mortality of 10.29 per cent. (see published report).

The Melbourne Hospital treated 351 cases, with mortality 22.22 per cent.; are your readers aware of these figures?

The matter stands thus: Homœopathy demands an infinitely greater knowledge of materia medica and therapeutics than does Allopathy. It demands a correspondingly accurate observation of the patient's symptoms and phenomena of his disease; and it demands an equally exact choice of the drug to be administered, both as to its qualitative and quantitative relation to the disease. When these conditions

of treatment are observed the cure effected often borders on the marvellous, and is only equalled by the astounding results of telegraphy, telephony, or spectrum analysis.

I am, &c.,

WM. GEO. WATSON, M.A., M.B., L.S.A., M.R.C.S.,
Late House Surgeon and Physicians' Assistant Uni. Coll. Hospl., London.

150 Elizabeth-street, Sydney,
16th April, 1890.

[If the last paragraph of our correspondent's letter is true it is a little singular that the reputedly most successful practitioners of homœopathy in this colony are men who have not had any opportunity of clinical study, but who, in many instances, by their own admission, have acquired their knowledge, such as it is, by mere reading. Our correspondent is also abroad in his idea of the action of the "American United States Legislature," which does not interfere with the regulation of the practice of medicine, but leaves the matter to the local legislatures of individual states, each of which acts independently in the matter. We refer our readers, and especially our correspondent, to a discussion on the merits of homœopathy in volume III., pp. 234, 277 and 285, of this journal, published in July and September, 1884. The extracts from the *Homœopathic World*, quoted by him, are mere assertions and must be taken for what they are worth.—ED. A.M.G.]

VITAL STATISTICS OF WESTERN AUSTRALIA FOR 1889.

THE total population of Western Australia on 31st December, 1889, was 43,698—viz., 25,066 males and 18,632 females. The total number of births during the year was 1,594 (825 males and 769 females), and the deaths numbered 611 (412 males and 199 females), of which 197 were under 5 years of age. One hundred and eighteen deaths were ascribed to *zymotic diseases* (dysentery and diarrhoea 45, remittent fever 12, typhoid 7, croup 11, influenza 8, &c.); 71 deaths were due to *constitutional diseases* (phthisis 39, cancer 20, dropsy 8); *local diseases* showed 211 deaths (heart diseases 39, convulsions 38, paralysis 15, enteritis 15, brain disease 13, pneumonia 12, bronchitis 11, &c.); 130 deaths were due to *developmental diseases* (old age 57, atrophy and debility 54); 41 deaths were due to *violence*, and 37 were ill-defined.

The meteorological information for the past year shows that the highest temperature recorded at Perth Observatory was 107° on the 7th January, and the lowest 36° on the 6th May; the mean shade temperature was 63°; the mean of barometer 30.029, and the mean humidity 68. Rain fell on 123 days, the total amount being 39.96 inches.

THE MONTH.

NEW SOUTH WALES.

THE provisions of the Imperial Medical Act have been extended to the Colony of New South Wales.

THE Board of Health have issued 600 circulars to medical practitioners in this colony asking for returns on cases of influenza which have occurred since the disease reached the shores of this colony. The Board desire that all members of the faculty in all parts of the colony who have met with or treated influenza cases will comply with the request, and forward replies at their earliest convenience.

THE number of vaccinations performed in the Colony during the year 1889 was 2,288, of which 2,252 were successful, and of these 642 were done in Sydney and suburbs, and 1,610 in the country districts; the proportion of vaccinations to births was 1 to 16. Of the successful cases during the year 1889, 343 were under 1 year, 829 from 1 to 5 years, 886 from 5 to 10 years, and 194 upwards of 10 years of age. The unsuccessful cases were 36, or 1·57 per cent. of the total number.

THE Scottish Universities Annual Dinner was held on the 18th April in the Sydney Catering Company's rooms, Pitt Street, Sydney. The gathering was well attended and passed off most pleasantly. The Hon. Dr. Renwick presided, and amongst those present were Professor Dr. Anderson Stuart, Dr. Vause, Dr. Ross, Dr. Huxtable, Dr. Scot-Skirving, Dr. Pockley, and Dr. MacLaurin.

A COMPLIMENTARY banquet was given by the profession of Sydney and suburbs to the Hon. Dr. MacLaurin, M.L.C., on April 14th, at the Sydney Catering Company's rooms, on the occasion of his return to the Colony from a visit to England. About 70 members of the medical profession sat down to an excellent dinner, Sir Alfred Roberts presiding. After the usual loyal toasts had been honoured, the chairman gave the health of the guest. Dr. MacLaurin, in reply, thanked them heartily for the honour they had done him. Professor Anderson-Stuart, in an excellent speech, proposed "Floreat res medica," to which Dr. Sydney Jones responded. The toast of "The Ladies" was proposed by Dr. Hull, and responded to by Dr. M'Allister. Dr. F. N. Manning proposed "The Health of the Chairman," which was enthusiastically honoured; and after Sir Alfred Roberts had replied, the gathering dispersed.

THE Senate of the University of Sydney has granted Professor Dr. Anderson Stuart leave of absence for twelve months, to enable him to visit Europe.

THE death is announced of Mr. David Salmond, L.F.P.S. Glas. 1840, who died at Burwood, near Sydney, on April 10th, at the age of 68. The deceased gentleman formerly occupied for many years the position of Government Medical and Health Officer at Rockhampton (Qu.), from which he retired about seven years ago, since which time he resided with relatives near Sydney. He was in receipt of a yearly pension from the Queensland Government of £174.

MR. OWEN FREDERICK SEYMOUR EVANS, L. et L. Mid., R.C.P. et R.C.S. Edin., 1881, died at Darvall-street, Balmain (Sydney), on the 29th April, aged 33 years. The deceased was the eldest son of the late Dr. O. S. Evans; he was an honorary surgeon of the Volunteer Naval Artillery, of the Balmain Cottage Hospital, and to the local Fire Brigade.

MR. REGINALD HUGH READ, M.R.O.S. Eng., 1859, L.S.A. Lond., 1858, died at his residence, at Coogee Bay, near Sydney, on April 22nd.

ALEXANDER KINKAR WATT, L.S.A. Lond., 1885, of Mitchell (Sunny Corner), is dead.

DRS. H. A. ELLIS and A. Jarvie Hood have been elected members of the honorary medical staff of the Sydney Hospital.

DR. LESLIE HOLLIS and Dr. Percy Townley have been elected resident medical officers at the Sydney Hospital.

DR. ALLAN CAMPBELL, after practising in Yass for over 40 years, has retired, but Dr. Thane, his late partner for six years, carries on his practice as formerly; Dr. Campbell left for Scotland by the German mail steamer "Kaiser Wilhelm II."

DR. F. G. CONNOR, late of Coraki, has succeeded to the practice of Dr. A. F. Parker, at Lismore.

DR. E. H. GOODE, late of Port Macquarie, has commenced practice at Granville, a suburb 12 miles W. of Sydney.

DR. THS. MASSEY HARDING has settled at Sunny Corner (Mitchell), the centre of a silver mining district, 124 miles W. of Sydney.

DR. A. W. HAWTHORNE, of Darlington (Sydney), has removed to Carcoar, where he has been appointed surgeon of the local Hospital, in place of Dr. Kelty, resigned.

DR. W. KELTY has removed from Carcoar to Orange.

DR. ANDREW W. NASH has removed from Wickham to Helensburgh, 27 miles S. of Sydney.

DR. R. T. PATON, of Trial Bay Prison, has been appointed acting Government Medical Officer and Vaccinator for Sydney during the absence on leave of Dr. Strong; Dr. Taylor, of Parramatta Asylum, has taken his place at Trial Bay.

DR. C. R. PIGG, a recent arrival, has settled at Hurstville, a suburb 9 miles S. of Sydney.

DR. HARMAN JOHN TARRANT, of Macquarie-street, Sydney, has been appointed a member of the Legislative Council of N. S. Wales.

DR. GEO. WATT has removed from Cobar to Yass, 190 miles S.W. of Sydney.

NEW ZEALAND.

THE Wellington Branch of the New Zealand Medical Association have passed the following resolutions and forwarded them to the Town Clerk:—1. "That this Association is of opinion that the introduction of the Contagious Diseases Act into Wellington would be beneficial and, under efficient administration, would have the effect of checking the spread of the diseases in question." 2. "That it is highly desirable that the Act should be enforced throughout the colony." The Wellington City Council adopted, on April 17, the report of the committee on the C.D. Act.

AT a recent meeting of the Wellington Hospital Committee a motion that the opinions of the Hospital Committees of Auckland, Christchurch and Dunedin be obtained, with a view of inducing the Government to bring the Contagious Diseases Act into force in these large cities, was negatived by 5 to 3.

THE late Hon. Robert Campbell has bequeathed £5000 to the Dunedin Hospital.

INFLUENZA is very prevalent in Invercargill, Christchurch, Wellington and Woodville.

DR. W. BLUNDEN, of Temuka, has succeeded to a baronetcy and Blunden Castle, Kilkenny.

DR. W. A. CHAPPEL, a graduate of the Univ. of New Zealand, has commenced practice at Motueka, on the West Coast of Blind Bay, 32 miles W. of Nelson.

DR. P. R. COOK, a graduate of the University of New Zealand, has commenced practice at Roxburgh, 100 miles W. of Dunedin.

DR. WALTER HISLOP has settled at Palmerston, the centre of a fine agricultural district, 41 miles N. of Dunedin.

DR. JAMES KILGOUR, J.P., of the Thames, was presented, on the 16th April, by his brother Justices at the Thames, on the occasion of his leaving that district to take up his residence in Auckland, with an address expressing their deep regret at his departure, and their sense of the loss which the district would sustain of the services of so efficient a judicial officer.

DR. D. B. LOGIE, late of Stratford (Taranaki), has left for Durban, South Africa, by the brigantine "Stanley."

QUEENSLAND.

THE Committee of the Townsville Hospital has accepted a tender for £380 for the erection of a Chinese ward. The money has been principally donated by the Chinese residents.

DR. F. CALDER, late of Lismore (N.S.W.), has commenced practice at Bundaberg.

DRS. CLATWORTHY, Nisbet, and Humphrey, of Townsville, Dr. Hunt, of Hughenden, and Dr. Paoli, of Charters Towers, have been elected members of the first Council of the North Queensland Medical Society.

DR. JAMES, of Croydon, and Dr. Paul, of Sandgate, have been appointed Justices of the Peace.

DR. DOYLE has been appointed Surgeon of the Cooktown Hospital.

DR. C. G. KENT, formerly resident medical officer at the Melbourne Hospital and late medical officer of the P. and O. s.s. "Chusan," running between London and India, has returned to the colony and commenced practice at Brisbane, his native city.

DR. H. B. NOLAN, a graduate of the Sydney University, has been appointed resident surgeon at the Too-womba Hospital, in the place of Dr. Aeneas McDonnell, who has left for China.

SOUTH AUSTRALIA.

THE following gentlemen have been appointed by the Executive Council to constitute the new Medical Board:—President, Dr. Patterson; secretary, Dr. Giles; members, Drs. T. K. Hamilton and C. E. Todd.

AT a recent public meeting held at Elliston it was decided to request the Council to again levy a health rate towards maintaining a resident medical practitioner.

MR. HENRY AYLIFFE, M.R.C.S. Eng., et L.S.A. Lond. 1852, died at his residence at Angaston on April 25, aged 71 years. The deceased gentleman arrived in the colony 38 years ago.

DR. P. J. W. TERNAN, of Burrundie (Northern Territory), has been appointed a Justice of the Peace.

DR. F. G. WRIGHT has commenced practice at Snowtown, 150 miles N. of Adelaide.

VICTORIA.

THE Board of Public Health has received about 150 replies to the circular recently sent out to the medical practitioners throughout the colony regarding the outbreak of influenza. These show that the epidemic is prevalent in nearly every part of Victoria, though it is of a rather mild character. In Gippsland, however, the number of cases has, so far, been small. A large amount of information concerning the symptoms of the malady, the methods of treating it, and its resemblance to fog fever, which was prevalent in Victoria five years ago, have been supplied by the medical practitioners.

THE Board of Public Health have resolved to advise the local councils to prosecute certain medical practitioners for neglecting to register cases of infectious disease. Two medical men in the southern suburbs of Melbourne were particularly referred to, and in each case they had neglected, on two occasions, to report cases coming within their knowledge.

THE following medical practitioners have been admitted to the University of Melbourne, *ad eundem gradum*:—A. M. Sheppard, M.B., Sydney; J. T. Harvey, M.B. Edinburgh; J. J. Flynn, Ch.B., Edinburgh.

It is intended to establish a Dental Hospital and College in Melbourne.

THE medical profession, in recognition of the services rendered by Mr. T. N. Fitzgerald, F.R.C.S.I., as President of the Medical Congress which sat last year in Melbourne, have decided to present him with a testimonial, and it has been arranged that the presentation shall take the form of a life-size portrait in oils, and Signor Catani, artist, has been entrusted with the commission of painting it.

WE regret to learn that Mr. Thomas Augustus Garlick, M.B. Melb., 1876, formerly resident medical officer at the Melbourne Hospital, died of pneumonia on the 19th April at his residence, at Murtoa, where he practised for the last twelve years, at the early age of 36 years.

WE regret to have to record the death of Mr. John Anderson Irwin, L.R.C.P. Ed. 1880, L.R.C.S. Irel. 1879, L.M. Rot. Hosp. 1878 who died on 12th April, at Rose Hill, Caulfield, near Melbourne, from typhoid fever, at the age of 34 years. The deceased gentleman came to the Colony early in 1882, and practised at Caulfield ever since; he occupied the position of Health Officer and Public Vaccinator for Caulfield and Malvern.

DR. J. H. CARNY, late of Kyabram, has commenced practice at Malvern, near Melbourne.

DR. G. W. DAMMAN left for Europe by the R.M.S. "Iberia."

DR. H. F. HAYES has commenced practice at Kambrook Road, Caulfield, near Melbourne.

DR. G. B. D. MACDONALD, late of Newbridge, has been appointed a Junior Medical Officer in the Hospitals for the Insane of the Colony.

DR. J. MCINERNEY, a recent arrival, has settled at Dimboola, 252 miles N.W. of Melbourne.

DR. J. C. M'KEE, of Eaglehawk, has been elected President of the Sandhurst District Football Association.

DR. G. A. WEBSTER, late of South Yarra, has succeeded to the practice of the late Dr. Irwin at Caulfield.

DR. A. J. WOOD, of the Melbourne Hospital for Sick Children, has gone to England.

PROCEEDINGS OF THE COLONIAL MEDICAL BOARDS.

The following gentlemen, having presented their diplomas, have been duly registered as legally qualified Medical Practitioners by the respective Boards:—

NEW SOUTH WALES.

Poggioli, Vitaliano, M.D., & M. Ch. Univ. Bologna 1876.
Morton, Gavin, M.B. Univ. Sydney 1890.
Morton, John, M.B. Univ. Sydney 1890.
Wilson, Colin George, M.B. M. Ch. Univ. Sydney 1889.
McDonnell, James John, M.B. M. Ch. Univ. Sydney 1889.
Townley, Percy Langford, M.B. Univ. Sydney 1890.
Sheppard, Arthur Murray, M.B. Univ. Sydney 1890.
Pigg, Cuthbert Ridley, L.R.C.P. Edin. 1888; L.F.P.S. Glasg. 1888; L.R.C.S. Edin. 1888.

NEW ZEALAND.

Cook, Percival Robert, M.B. Univ. of N.Z., 1890.
Fooks, Ernest Edward, M.B. Univ. of N.Z., 1890.
Fulton, Robert Valpy, M.B. & Ch. M. Edin.
Hialop, Walter, M.B.
Chapple, William Allan, M.B. Univ. N.Z. 1890.
Gilray, George Vetch, M.B. & Ch. M. Ed.
Lomax-Smith, Montagu, M.R.C.S.E.; L. & L. Mid. R.O.P. Edin 1888.

QUEENSLAND.

Calder, Frank, M.R.C.S.E., L.R.C.P., 1888.
Doyle, Andrew Aloysius, L.R.C.S. Irel., 1884; L.K.Q.C.P. Irel., 1885.
Kent, Charles George, M.B. 1884; Ch.B. 1885 Melb.
Nolan, Herbert Russell, M.B. & Ch. M. Syd., 1890.

TASMANIA.

Jackson, Charles Granville, L.K.Q.C.P. Irel., 1885.
Stevenson, Frederick Charles, L.R.C.S. Irel., 1879; L. & L. Mid. K.Q.C.P. Irel., 1880.

MEDICAL APPOINTMENTS.

Fooks, Ernest Edward, M.B. Univ. N.Z., to be Assistant Superintendent at the Seaside Asylum for the Insane, near Dunedin.
Fulton, Thomas Kensington James, L.R.C.P. & R.C.S. Ed.; L.F.P.S. Glas., to be Health Officer and Medical Officer to Police and Gaols and Paupers for Devonport and neighbourhood, Tas.
Gandevia, Navroji Bamanji, M.R.C.S.E.; L.R.C.P. Lond., to be Health Officer for Shire of Portland, Victoria.
Kennedy, John William, F.R.C.S. Irel.; M.K.Q.C.P. Irel., to be Visiting Surgeon to the Gaol at Hay, also Govt. Medical Officer and Vaccinator for the District at Hay, N.S.W., vice Dr. Casey, resigned.
Lawton, Frederick, M.R.C.S.E., to be Health Officer for Shire of Lancefield, Vic.
Salter, George Herbert, M.R.C.S. Eng., to be Health Officer for Shire of Ballarat, Vic., vice Dr. G. F. Wickens, resigned.
Scott, Henry James Herbert, L.R.C.P. Lond.; M.R.C.S.E., to be Govt. Medical Officer and Vaccinator for the District of Scone, N.S.W.
Spencer, Walter, M.D. Brux.; M.R.C.S.E.; L.R.C.P. Ed., to be Health Officer to Police and Gaols and Paupers for District of West Devon, Tas.
Stanton, Thomas, M.B. Dub.; L.R.C.S. Irel., to be Health Officer for Koroit, Vic.
Von Lossberg, W. Henry, M.D., to be Govt. Medical Officer and Health Officer at Ipswich, Qu.
Wolfenden, James Jackson, L.R.C.S. Irel.; L.K.Q.C.P. Irel., to be Health Officer for St. Arnaud, Vic.

MEDICAL PRACTICE for Sale, country railway town, income £1,500; splendid resi'ence; no clubs; good investment; terms £800, half cash. D. W., Box 414, G.P.O.

We have received from Messrs. Curtis and Co., Pharmaceutical Chemists, London, a sample bottle of their "*Pasma, or Healing Powder*," said to be recommended by Drs. Liveing, Malcolm Morris, Calcott Fox, the late Sir Erasmus Wilson, Tilbury Fox and others, for tender and irritable skin, eruptions, eczema, &c.

BIRTHS, MARRIAGES, AND DEATHS.

. The charge for inserting announcements of Births, Marriages, and Deaths is 2s. 6d., which should be forwarded in stamps with the announcement.

BIRTHS.

BAGE.—On the 22nd March, at South Yarra, Melbourne, the wife of Dr. Charles Bage, of a daughter.
BROWN.—April 14, at Parramatta, N.S.W., the wife of W. Sigismund Brown, of a son.
CHEETHAM.—On the 30th March, at Hawthorn, Melbourne, the wife of Dr. R. J. Cheetham, of a daughter.
CLENDINNEN.—On the 1st April, at Hawksburn, Melbourne, the wife of F. J. Clendinnen, M.D., of a daughter.
COLLINS.—On the 29th April, at The Residence, Peak Downs Hospital, Clermont, Queensland, the wife of M. J. Collins, L.R.C.S. Edin., etc., of a daughter (Kether).
HAMILTON.—On the 17th April, at Laura, S.A., the wife of C. W. Hamilton, M.B., of a son.
HANKINS.—April 28, at 49 Phillip-street, Sydney, the wife of George T. Hankins, of a daughter.
HENRY.—April 28, 1890, at Warialda, N.S.W., the wife of T. J. Henry, L.R.C.P. and L.R.C.S.E., of a son.
HOSKINS.—On the 27th April, at Fingal, Tasmania, the wife of Dr. F. Hoskins, of a son.
LOVE.—On the 28th March, at Brisbane, the wife of Wilton Love, M.B., of a daughter.
MAHER.—April 26, at Burwood, the wife of W. Odillo Maher, M.D., Sydney, of a daughter.
TAYLOR.—On the 32nd March, at Brisbane, the wife of W. F. Taylor, M.D., of a son.

MARRIAGES.

LAMROCK-CAMPBELL.—On April 24, at the Presbyterian Church, Elsternwick, Victoria, James Lamrock, M.B., of Kogarah (Sydney), to Margaret Adeline, eldest daughter of J. C. Campbell, of Elsternwick.
MARWOOD-COTTIER.—On the 3rd April, at St. Matthew's Church, Prahran, Dr. Arthur William Marwood, of Geelong, Victoria, to Isabella Field, elder daughter of Daniel Cottier, of London.
O'SULLIVAN-MITCHELL.—On the 16th April, at Hawthorn (Melbourne), by the Rev. Thomas Armstrong, E. F. O'Sullivan, M.D., of Yarrowonga, Vic., to Fannie Elizabeth, daughter of J. F. H. Mitchell, Hawthorn.
PACEY-CLARKE.—On the 16th April, at Geelong, by the Rev. J. Hanwood Toms, Fred. J. Pacey, L.R.C.S., &c., Edin., of Drysdale, Vic., to Mary Alice, second daughter of Richard Clarke, J.P.

DEATHS.

FLETT.—On the 3rd May, at Hawthorn, Melbourne, Bruce Pole wife of William Simpson Flett, M.D., of Fitzroy, aged 40.
LYTTELTON.—On the 17th April, at Adelong, N.S.W., Francis Angelique, wife of W. M. Lyttelton, M.D., eldest daughter of E. R. Lennox, of Stawell, late of Geelong, Victoria, aged 37.
WILLIAMS.—On the 17th April, at Queenscliff, Victoria, Jane, wife of Dr. D. J. Williams.

L. BRUCK, Medical Bookseller, Sydney,

Has added the following recent publications to his magnificent stock of Medical Books for sale:—

SQUIRE'S COMPANION B.P., 15th ed., 1890, 10s. 6d.
HART & BARBOUR, MANUAL OF GYNÆCOLOGY, 4th ed., 1890, 25s.
CHURCHILL'S MEDICAL DIRECTORY FOR 1890, 14s.
PYE, SURGICAL TREATMENT OF DEFORMITIES OF CHILDREN, 1890, 7s. 6d.
QUAIN'S DICTIONARY OF MEDICINE, 2 vols., New ed., 1890, 34s.
HEATH, DICTIONARY OF SURGERY, 2 vols., 3rd ed., 1889, 32s.
NIXON, HOSPITAL PRACTICE AND PHYSICAL DIAGNOSIS, 1889, 9s.
BEVAN LEWIS, TEXT BOOK OF MENTAL DISEASES, 1889, 28s.
MACFARLANE, INSOMNIA AND ITS THERAPEUTICS, 1890, 12s. 6d.
WINCKEL'S DISEASES OF WOMEN, 2nd ed., 1889, 12s. 6d.
EUSTACE SMITH, DISEASES IN CHILDREN, 2nd ed., 1889, 32s.
TAYLOR'S PRACTICE OF MEDICINE, 1890, 15s.
CRIPPS, DISEASES OF RECTUM AND ANUS, 2nd ed., 1890, 12s. 6d.
CRIPPS, CANCER OF THE RECTUM, 3rd ed., 1890, 6s.
ALLINGHAM, INTERNAL DERANGEMENTS OF KNEE JOINT, 1889, 5s.

&c., &c., &c.

Postage extra, at the rate of 1s. 6d. to the £ of order.

REPORTED MORTALITY FOR THE MONTH OF MARCH, 1890.

Cities and Districts.	Population.	Births Registered.	Deaths Registered.	Deaths under Five Years.	Number of Deaths from									
					Measles.	Scarlet Fever.	Croup and Diphtheria.	Whooping Cough.	Typhoid Fever.	Dysentery and Diarrhoea.	Phthisis.	Heart Disease.	Cancer.	Child-bearing.
N. S. WALES.														
Sydney	128,880	294	183	52	...	...	1	5	8	5	12	6	7	1
Suburbs	252,850	789	276	133	...	..	11	3	15	24	24	15	11	4
NEW ZEALAND.														
Auckland	33,307	70	39	18	...	...	1	...	3	7	5	1	1	...
Christchurch...	17,116	33	32	7	...	...	...	...	1	4	1	...	1	...
Dunedin	24,168	51	28	13	...	...	...	...	1	4	2	3	3	...
Wellington	31,028	73	13	13	..	...	1	...	1	9	4	6	...	...
QUEENSLAND.														
Brisbane	51,689	180	67	27	} ...	2	2	2	6	6	9	3	3	1
Suburbs	21,960	150	40	19		...	...	...	...	...	...	...	...	...
SOUTH AUSTRALIA	318,543	902	313	126	...	1	23	3	14	23	19	21	14	3
Adelaide	44,581	76	64	16	...	...	...	...	4	3	6	5	4	...
TASMANIA.														
Hobart	35,728	77	58	23	...	...	...	1	2	7	2	5	1	...
Launceston	21,981	59	40	14	...	...	2	...	3	5	2	4	2	...
Country Districts.....	91,163	289	98	...	...	...	6	...	4	16	...	...	...	...
VICTORIA.														
Melbourne	75,400	...	...	} ...	...	...	...	...	...	...	...	...	...	...
Suburbs	362,385	...	...		...	...	...	...	...	...	...	...	...	...

METEOROLOGICAL OBSERVATIONS FOR MARCH, 1890.

STATIONS.	THERMOMETER.					Mean Height of Barometer.	RAIN.		Mean Humidity.	Prevailing Wind.
	Maximum Sun.	Maximum Shade.	Mean Shade.	Minimum Shade.			Depth.	Days.		
							Inches			
Adelaide—Lat. 34° 55' 33" S.; Long. 138° 36' E. ....	...	97.7	71.2	49.8	29.937	...	...	...	...	...
Auckland—Lat. 36° 50' 1" S.; Long. 174° 49' 2" E.	140.7	78.6	61.1	46.6	...	2.620	8	68	...	...
Brisbane—Lat. 27° 28' 3" S.; Long. 153° 16' 15" E.	146.5	86.1	72.8	60.5	29.996	21.360	26	85	E.	...
Christchurch—Lat. 43° 32' 16" S.; Long. 172° 38' 59" E.	143.2	91.2	58.3	35.2	...	1.983	11	66	...	...
Dunedin—Lat. 45° 52' 11" S.; Long. 170° 31' 11" E.	135.8	80.6	55.8	42.6	...	3.282	12	75	...	...
Hobart—Lat. 42° 53' 32" S.; Long. 147° 22' 20" E. ....	...	91.8	62.6	44.2	30.073	2.56	11	78	...	...
Launceston—Lat. 41° 30' S.; Long. 147° 14' E. ....	...	84.2	65.3	33.5	30.099	3.22	8	74	...	...
Melbourne—Lat. 37° 49' 54" S.; Long. 144° 58' 42" E. ....	...	...	...	...	...	...	...	...	...	...
Sydney—Lat. 33° 51' 41" S.; Long. 151° 11' 49" E. ....	...	77.6	69.5	57.6	30.088	17.13	25	82	N.E.	...
Wellington—Lat. 41° 16' 25" S.; Long. 174° 47' 25" E.	139.7	76.8	60.2	43.5	...	2.230	13	69	...	...

Office of Board of Health,
Sydney, 16th April, 1890.

50 VICTORIÆ No. 17.

"DAIRIES SUPERVISION ACT."

THE attention of the Medical Profession and the public generally is hereby drawn to the 7th, 11th, and 12th sections of the above Act, and the Proclamation of His Excellency the Governor and the Executive Council, dated 24th November, 1886.

By order of the Board,
EDMUND SAGER,
Secretary.

Infectious Diseases in Dairy Premises, &c., to be reported immediately.

7. On the appearance of any case of infectious disease in any dairy premises or milk-store within a district the householder or occupier or if there be no such householder or occupier the owner of such premises or store and also the medical practitioner attending the case shall immediately report in writing such case to the proper authorities in manner following that is to say if the case occur within the City of Sydney then the reports of the case shall be delivered to the officer in charge at the nearest of any police station within such district or to the Secretary of the Board of Health and if the case occur beyond the City of Sydney then the reports shall be delivered to the nearest Officer or Police Clerk of Petty Sessions or to the Government Medical Officer of the district within which the case has occurred.

Penalties, &c.

11. Every person who shall wilfully disobey or act in violation of any of the provisions contained in either of the last six preceding sections or shall resist or wilfully obstruct any person in the lawful exercise of any of the powers conferred under section four of this Act or shall without lawful excuse neglect or disobey any requirement made under the provisions of section four hereof or shall neglect or refuse to obey any order or direction of the Board of Health or any local authority made under the said section within the time limited in that behalf by such order or direction such person shall for every such offence be liable to a penalty not exceeding twenty pounds.

Governor to declare what are Infectious Diseases.

12. The Governor on the recommendation of the Board of Health shall as soon as practical after the passing of this Act declare what are infectious diseases for the purposes of this Act and may thereafter from time to time add to alter or amend such declaration as may seem necessary or advisable. And the Board of Health shall forthwith furnish a copy of each such declaration and of each such addition alteration or amendment to every local authority.

NEW SOUTH WALES, } Proclamation by His Excellency The Right Honourable CHARLES ROBERT,
to wit. } BARON CARRINGTON, a Member of Her Majesty's Most Honourable Privy
(L.S.) } Council, Knight Grand Cross of the Most Distinguished Order of Saint
CARRINGTON, } Michael and Saint George, Governor and Commander-in-Chief of the Colony
Governor. } of New South Wales and its Dependencies.

WHEREAS the Board of Health has recommended that the diseases hereinafter mentioned be declared infectious diseases for the purposes of the "Dairies Supervision Act:" Now, therefore, I, CHARLES ROBERT, BARON CARRINGTON, the Governor of the Colony of New South Wales, in pursuance of the provisions of the above-cited Act, and with the advice of the Executive Council, do, by this my Proclamation, declare the diseases named hereunder to be infectious diseases, viz.:—

A.—In human beings—Cholera.

Enteric Fever.
Small Pox.
Scarlet Fever.
Diphtheria.
Measles.
Syphilis.

B.—In animals.—Apthæ.

Cancer.
Pleuro Pneumonia
Splenic Fever.
Tuberculosis.
Udder—inflammations,
eruptions, or warts of.

Given under my Hand and Seal, at Government House, Sydney, this twenty-fourth day of November, in the year of our Lord one thousand eight hundred and eighty-six, and in the fiftieth year of Her Majesty's Reign.

By His Excellency's Command,
GOD SAVE THE QUEEN! GEORGE R. DIBBS.

AUSTRALASIAN MEDICAL GAZETTE.

ORIGINAL ARTICLES.

NOTES OF A CASE OF ACUTE YELLOW ATROPHY OF THE LIVER—WITH REMARKS.

By A. MUELLER, M.D., OF YACKANDANDAH,
VICTORIA.

THE reasons that have induced me to publish the subjoined notes are two-fold. In the first place the disease they deal with is comparatively rare, more especially in childhood, and at the same time one of the most formidable ones we may be called upon to deal with. But acute yellow atrophy of the liver has a third feature that still more imperatively calls for the publication of every well-observed case—it is extremely obscure. Our best authorities are at variance as to its nature and treatment, and it is very questionable whether the most modern and most generally accepted views of it, as expressed by the name *Hepatitis diffusa acuta*, are correct and final. As the case I am about to relate is very typical and well-marked I flatter myself that it may contribute a little towards the solution of the problems we are confronted with in this insidious disease. To remove any doubt as to the correctness of my diagnosis I have made the account as minute and detailed as was possible without its becoming tedious.

W. G., a boy 11 years old, was brought to my door lying under the seat of a waggonette, on the night of Sunday, the 30th of March last. As a glance at him revealed to me an apparently very serious condition, I had him at once carried in blankets into my surgery, and for nearly an hour kept him under observation there.

Tall for his age, but very spare and thin; countenance pinched, of an ashy hue, with a decidedly yellow tinge, especially perceptible on conjunctiva, expressive of much uneasiness and distress. Is throwing himself about, and at times has to be kept down by force, constantly *delirious*, talking incoherently, and can only momentarily be roused into consciousness and made to answer questions by being spoken to loudly. Temperature of body decidedly *subnormal*; hands and feet almost cold. Respiration quick and somewhat laboured, 30 per minute. Pulse small and thread-like, 120 per minute. Tongue white, with a slight yellow tinge. Percussion and respiratory sounds normal over both lungs; percussion over right lobe of liver elicits expression of pain; area

of hepatic dulness vertically scarcely two inches over right lobe, entirely disappeared over left, where sound is purely tympanitic; area of spleen dulness increased by nearly an inch all around the organ. Whilst being examined vomited a few spoonfuls of bile-stained mucous of a very foetid odour, and subsequently passed a clay-coloured stool almost devoid of bile colouring. Of the urine voided at the same time I managed to catch about an ounce for examination—found it to contain traces of albumina and large quantity of bile. A saffron-coloured sediment, formed during the night, showed under the microscope epithelial detritus and yellow needle-like crystals of leucine.

History of Case.—Boy had been somewhat moping during the previous day, complaining of lassitude and headache, but did not refuse his food and kept up till nine o'clock on Saturday night, reading his school books. During the night the headache became very violent, and vomiting set in, followed by great restlessness and violent pains in the right side. Had passed several palish motions, and frequently voided small quantities of dark yellow urine. On Sunday morning the first signs of delirium set in, and this increased rapidly in violence, becoming towards evening almost furibund, and at last, rousing the parents into action, which resulted in the child being brought to me, a distance of 16 miles.

Diagnosis.—There could hardly be a doubt as to the name to be given to this disease. The early delirium, combined with the subnormal temperature, the pain in the right hypochondrium, the reduced area of hepatic dulness, the spleen enlargement, and the extreme feebleness of the heart action, were both singly and collectively thoroughly pathognostic symptoms, admitting of but one interpretation. More difficult, however, was the question, by what subtle influence this almost hopeless state of collapse had been brought about in less than 24 hours? I suspected bilestasis, judging from stools, urine and vomiting; but healthy bile, temporarily dammed up in the liver would not bring about the wholesale collapse of bile cells, which was evidently going on, nor would it, if absorbed into the system, cause delirium and rapid collapse. But the question suggested itself to me: *Might not bile retained for some time, and having become putrid in consequence, gradually soften the cell membrane, and ultimately cause it to give way?* Its contents, filtering into the surrounding tissue, would there, by rapid decomposition, cause diffuse hepatitis, and absorbed into the system might act as a subtle depressing poison, causing deli-

rium and the whole complex of symptoms. I was aware that these were somewhat unfashionable views of the disease, but preferred to follow my own judgment rather than the dictum of leaders. Moreover, the principle one of these, Frerichs, gives such hopeless prognosis, and such indifferent treatment for this formidable disease, that following him would have been equivalent to giving up my patient almost without a struggle.

He tells us in his splendid and elaborate work on "Diseases of the Liver," that acute yellow atrophy is always fatal, and doubts the correctness of diagnosis in the cases of recovery on record. Bearing in mind that, in these cases, drastics had been given freely, and that most of these have cholagogue action, I determined on *treatment* having for its object the speediest possible removal from the liver of any retained, and in all probability, putrid bile, and for this purpose selected certain American cholagogues as most promising of success. As the mixture I then prescribed was used throughout the case, I give the prescription in full.

R. Tr. Euouymin
(5 %) Iriain aa ʒii.
Potassae Bicarb. ʒiij
Mist. Podoph. comp.
ad ʒ iv
C. cochl. med. ii horis.

The mist. pod. comp. is a formula of my own, which, for convenience sake, my chemist keeps in stock. It consists of Tr. podoph. and leptandrin with sodæ pot. tart., glycerine and inf. rhei conc. I have found by long experience that these valuable American cholagogues supplement each other in their effects, and, therefore, am in the habit of combining them; hence this rather composite prescription, which I directed to be given again, if rejected, half-an-hour after the vomiting. I also ordered a liniment of equal parts of ol. croton and ol. terebinth to be rubbed over the liver region, and to the most painful part of it an empl. lyttæ of the size of a small hand to be applied.

When I saw the boy again on Monday morning all the symptoms were aggravated; delirium was more violent; pulse 135; extremities cold; vomiting persistent. Some stools had passed showing a little more bile pigment, but Icterus was more pronounced, and though the blister had been effective pain in the right side appeared but little relieved. I now ordered a hydrocyanic acid c. liq. bismuthi mixture to be given with the cholagogue and a strong mustard plaster to be applied to the epigastrium. As the latter mixture was invariably rejected, I tried the same remedies in powder form to be enveloped in wafers, but could not prevent the boy from chew-

ing them and then spitting them out. Pills also he would not swallow, though I placed them low down into the pharynx. The mixture was therefore again resorted to and given frequently in smaller doses, in the hope that sufficient of it would adhere to the coats of the stomach to cause reflex action on the bile duct.

During Monday no perceptible change occurred. In the evening the pulse had risen to 140, and the boy had to be held down in bed, as he was throwing himself about violently and wanted to get out all the time. This want of success, however, did not discourage me to persevere in the treatment, and I had the pleasure of seeing a marked improvement on *Tuesday morning*. Some dark, tarlike and very putrid stools (atrabilious) had passed during the night, and after each of them the boy's condition had visibly improved. The delirium abated, and towards morning he had a few hours' sleep, the first since Saturday night. When I saw him at 9 a.m. he was quite rational and extended his hand to me; pulse had gone down to 95; respiration was much nearer the normal, and the pain in the right side was much relieved. Icterus also was less marked, but tongue still coated with a thick yellow fur. Ordered the cholagogue and hydrocyanic acid mixtures to be continued, and nourishment in the form of raw eggs beaten up with water; chicken broth and beeftea to be given frequently.

Tuesday evening.—The more hopeful aspect of the case had, if anything, improved, but vomiting was still very troublesome. No further stools had passed. Ordered another mustard plaster to the epigastrium, and larger doses of the hydrocyanic acid and bismuth mixture.

Wednesday morning.—Had a very bad night, delirium having returned early and lasted till daylight. Was conscious when seen at 10 a.m.; pulse 106; temperature cool, subnormal. Vomiting had ceased at last, and a large atrabilious evacuation had passed, dark and thick like tar and very putrid, but *mostly soluble in water and quite free from blood corpuscles*. Ordered the cholagogue mixture to be repeated with inf. sennæ conc. instead of inf. rhei and an addition of liq. cascarae, chicken broth, &c., very frequently.

Wednesday evening.—Looks very bad, eyes sunken, expression of face anxious and very painful; pulse 120; temperature still subnormal; sleeps much; no delirium and vomiting. Had two putrid black stools again during the day, but still complains of pain in right side and tenderness all over the abdomen. Urine frequent but scanty, still containing traces of albumina and much bile; yellow sediment still showing crystals of leucin and also tyrosin. To continue cholagogue mix-

ture and have an enema of castor oil, with soap, salt and water ; as much nourishment as possible.

Thursday morning.—Perfectly free from delirium, pain in abdomen and right side greatly relieved, but is very low. Pulse hardly perceptible, 120 per minute ; respiration 35 ; temperature very low. Yellow fur on tongue gone, icterus scarcely perceptible ; vomiting ceased. Hepatic dulness on percussion still absent over left lobe, and area also decreased, if anything, over right lobe. The enema had caused two more stools of black putrid bile. Ordered five drops of acid nit-muriat dil. every two hours in a little cold water and egg beaten up with white wine and water or chicken broth and beef tea very frequently.

Thursday evening.—Apparently sinking, lies listlessly in a stupor, from which he can only be roused for a short time. Pulse 120 and very small ; respiration 30 ; temperature very low ; extremities cold.

Friday morning.—Still continues in a listless condition, but takes broth, eggs and wine freely. Had two more stools, still dark, but containing healthy fæces with a quantity of more healthy bile. Tongue moist and clean, but very sore at point, where aphthous ulcers are developing ; lips covered with a dark crust and easily bleeding. Temperature now quite normal ; pulse fuller, 116 ; respiration 28. Tenderness in abdomen and over right side almost gone, urine showing no trace of albumen and very little bile.

Friday evening.—Much improved in every respect, has been out in the open air for some hours wheeled about in a perambulator, and taken food, including bread and butter, with much relish. Pulse much stronger—90 per minute ; respiration, 25 ; temperature, normal. Passed two healthy bilious motions.

Saturday morning.—Pulse, 80 ; temperature, normal ; tongue clean, but showing more aphthæ. Has voided urine frequently during night, also passed two healthy bilious stools ; slept well and feels well, complaining only of slight tenderness on pressure over abdomen, and also soreness of mouth. The latter somewhat retarded convalescence, as it developed into stomacæ, necessitating the use of Potassæ Chloras. This in its turn was followed by bilious diarrhœa, with which, however, I did not interfere, taking it for a final effort of the *vis naturæ medicatrix*, which no doubt it was, as its effects were beneficial. Patient returned home on the 15th of April, fully convalescent.

Remarks.—Without venturing to draw final conclusions as to the nature of the disease under review from this single case I may be permitted to point out the lessons it teaches, or which, at least, it has taught me.

The first and most important one, around which the whole question turns, appears to be, that acholia or absence of bile, as disclosed invariably at autopsies, is not a characteristic feature of the disease throughout, but merely its final result. When death takes place the bile-secreting cells have generally all perished, and the original contents of the bile ducts and gall bladder have been thrown out, leaving the latter comparatively empty, containing only small quantities of a pale liquid, in which, however, significant black particles are still swimming, the last remnant of the real *materies morbi*. This liquid is merely the drainage from the disorganized gland, in which bile secretion must necessarily cease after the cells have perished. But Frerichs is decidedly in error when he assumes this absence of bile to be the cause of the pale clay-coloured stools, that are characteristic of the first stage of the disease, for exactly such stools may frequently be observed in biliary congestion, when catarrh of the duodenum or of the bile ducts prevents the flow of bile. Next in importance comes the question : whence come and what are the dark, tenacious, tar-like masses that are sometimes vomited, but invariably passed per anum in this disease ? Frerichs assumes them to result from hæmorrhage. I have looked in vain for blood corpuscles in the sediment that remained on the filter after I had mixed about a spoonful of this black mass with water, in which I found it almost completely soluble. Though I had neither the means nor the time to make an analysis that alone could settle the point, I feel confident that these dark stools were wholly and solely the product of the liver ; that they were bile, inspissated and putrid by long retention. That putrid bile of a very dark colour can be carried about with apparent impunity, or at least with comparatively slight disturbance of the general health, no observant practitioner can have failed to notice and must often have verified under appropriate treatment when finally the person is driven to seek his aid. Modern medicine, I fear, has gone too far in striking what our forefathers called *status atrobiliaris* from its nomenclature, merely because black bile may be, and no doubt was frequently, confounded with black blood. Even if I had found blood corpuscles in the stools of my patient I should not have changed my opinion about them, for they caused irritation and even slight excoriation at the anus, and might easily have given rise to slight capillary bleeding from the mucous membrane of the intestines. That in flowing over the latter they caused the tenderness all over the abdomen, which is a constant feature of the disease, I infer from the fact that in the case under review this tenderness was not complained of until the black stools made their appearance.

In this dark, putrid bile, then, we have the *materies morbi*, the *prima et sola causa* of yellow atrophy. In accumulating more and more, and finally filling the bile ducts up to the finest ramifications and ultimate ends in the secreting cells, together with these cells themselves, this thick, tenacious and adhesive bile must become more stagnant from week to week and also more putrid and alkaline, more apt to act as a solvent on the delicate cell-membrane. The latter, moreover, in secreting more bile from day to day has to withstand the additional strain of over-expansion, as the contents of the bile ducts must necessarily obstruct the downflow of the newly-made bile. Under these circumstances, sooner or later, unless nature finds a vent, a breakdown must take place at the point of least resistance, which is the cell membrane; and as cell after cell gives way and allows its contents to ooze out into the surrounding tissue, the ominous symptoms of yellow atrophy are ushered in. First of these in the order of time comes hepatitis, set up wherever a cell bursts, and sends its sharp, almost corrosive contents into the connective tissues surrounding it, but it is a symptom of the disease only—not the disease itself. Its course is marked by broad bands of exudations traversing the liver after death, but unlike all other inflammations it runs this course under a subnormal temperature. Whence then this temperature so characteristic of the disease? Whence the peculiar delirium, unaccompanied by fever, together with the alarming depression of heart force, from the very commencement of this strange disorder? Anomalies like these can only result from the toxic effects of a specific poison, and for this poison we have to seek in the liver itself. Decomposition of the putrid bile evidently takes place almost immediately after it has left the cells. Two of the products of this decomposition—leucin and tyrosin—are found copiously deposited in the destroyed gland, but both these substances have no specific toxic effects, a third one evidently is formed more subtle and insidious and less easily detectable. That the violence of these symptoms stands in direct proportion to the amount of mischief going on in the liver by the collapse of cells was most patent in this case, for they abated immediately on the black stools beginning to come away freely, the engorged condition of the bile ducts being lessened and the downward flow of the previously stagnant bile freeing the cells from the pressure that threatened to burst them. If these conclusions are correct the prognosis in acute yellow atrophy seems to depend on the time when the engorged state of the bile ducts is relieved. If the disease is recognized in its incipency, and an effective chologogue

treatment* is initiated before too many of the cells have perished, the outlook would appear by no means hopeless, as it seems possible to arrest the morbid process at any time. With a large number of cells perished and the system in consequence saturated with the subtle, depressing poison generated in the liver, no treatment can avert the doom of the victim, and the prognosis becomes utterly hopeless, for the cells once perished are lost and cannot be replaced. It may appear presumptuous on my part to advocate a certain line of treatment from the experience of a single case—that is in reality the first one I have ever closely observed—and it would indeed be presumption of a most odious kind but for the fact of there not being known any treatment of this disease that can show anything else than autopsies for its result. Chologogues in yellow atrophy of the liver occupy the same place which strychnine does in snake poisoning; they have no rival, and if they do not benefit they will not hurt. Moreover, it must be remembered that in assuming polycholia rather than acholia to prevail in the first stage of yellow atrophy I do not stand alone. Rokitansky, Hensch, Dutsch, Budd, &c., held the same view, but only failed to point out that quality as well as quantity of bile has to be reckoned with in accounting for the cell-collapse.

It was most fortunate for the little sufferer that I caused him to be carried into my surgery and kept him there for an hour under close observation, for it enabled me to complete my diagnosis at once and determine on a course of treatment, that with the rapid course of the disease might have been too late if delayed only for a few hours. The vomiting of bile-stained mucus of the unmistakable foetid odour of putrid bile first caused me to suspect its presence, and this suspicion was confirmed when I found the urine overcharged with bile, and the stools almost entirely deficient of it. These three finger-posts, all pointing in one direction, might have been observed too late, if observed at all, but for this precious hour's close observation.

To sum up finally, it would appear from this case that the condition of the liver preceding an ordinary idiopathic attack of acute yellow atrophy is very similar to that which arises in consequence of the compression and gradual obliteration of the ductus choledochus and hepaticus, sometimes observable in scirrhus of the liver. The bile dammed up for months in such cases gradually becomes putrid. The liver begins to shrink, and one after the other the symptoms

* We would call the attention of the author to two cases reported in the *A. M. Gazette* for July, 1889, by Dr. Skot-Skriving and the Editor of this journal, which, we think, were without doubt Acute Yellow Atrophy, in which the American Chologogues were used with similar success.—Ed. *A.M.G.*

of yellow atrophy, with a course generally sub-acute, are ushered in. After death the liver shows exactly the same characteristic appearance, with this difference however, that above the obstruction the bile ducts are gorged with bile, whilst in an idiopathic attack of the disease they are found almost empty, their original contents having been forced out by the violent vomiting that invariably accompanies the disease.

To understand complete bile-stasis with the ductus choledochus distended with bile, we must bear in mind that its orifice at the plica longitudinalis duodeni is very small; that the duct runs through the duodenal membranes in very, very oblique direction, and that it is only very sparsely supplied with muscular fibres. Owing to the very powerful muscular coat of the duodenum, however, distention of the duct ceases as soon as it has perforated that coat; and it is moreover compressed and made less permeable by the weight of the bile-gorged higher portion of it pressing on the duodenum. I have repeatedly convinced myself at *post mortem* examinations by careful dissection that even in ordinary bile-stasis, which frequently accompanies fatal diseases, these opposite conditions of distension in the free compression in the duodenal portion of the duct co-exist, and I have no doubt that both conditions increase *pari passu*. Another feature we must not lose sight of, is the condition of the bile in what is most appropriately called the atrabiliary state. As already stated and proved by ocular demonstration in the case related above, the bile is thick, tenacious and adhesive, besides being black and putrid; it flows with difficulty; it is also present in large quantity, judging from the masses of it that are evacuated in the course of the disease. To have contained them all the bile ducts must have been in a highly distended state, and by this very distention have lost nearly all their contractile power, which latter, moreover, is only in the choledochus effected by muscular fibres. Thus, with the latter duct distended to a diameter of a quarter, and even half an-inch, and the others together, with the gall bladder in proportion, the flow of bile into the duodenum may become as completely suspended as through compression of the ducts by a tumor from without. To the objection that this condition cannot exist without producing both local and general effects of a serious kind, apart from the ultimate result, I would reply that it comes about very gradually, and that the distended bile vessels adapt themselves to it in consequence, without anything but a feeling of soreness and tenderness in the epigastrium, together, perhaps, with want of appetite and occasional nausea being felt, whilst the general effects would be those produced by the absence of

bile in the digestive process, principally showing in general lassitude and gradual disappearance of the fat deposits. The individual would, no doubt, be in very indifferent health, but probably not sufficiently so to discontinue his or her usual mode of life, or to seek medical advice. In the majority of cases also, nature, the "great physician," will find a vent before the final catastrophe, "cell collapse," sets in. Were it not so, acute yellow atrophy of the liver would not be so rare a disease. A violent fit of vomiting may at any time restore the bile discharge, and will probably be followed by bilious diarrhoea or dysentery, in the course of which the liver clears itself; or the person, avoiding the doctor, may fly for relief to one or the other of those numerous drastic patent medicines, most of which have a certain amount of cholagogue action. That this action, and this only, is required in acute yellow atrophy, I feel most fully convinced of. Initiated early and pursued vigorously, it seems to offer the only loophole of escape from otherwise inevitable death. That it always will prevent it I am not rash enough to assert; but since we may safely credit a fatal issue to the disease itself, there is no reason why the treatment proposed by me should not be adopted.

CASE OF POISONING BY "WILD MELONS."

BY J. FRANCIS SOUTER, M.B., LAKE CUDGELLICO, N.S.W.

Having recently come to reside in the colonies, I am not aware if such cases as the above-mentioned be common or not, but think that a short account of a case which has just come under my notice may not be devoid of interest to others, who, like myself, are more or less unacquainted with the toxic properties of the commoner plants in this country. At the same time I shall be indebted to any one who will further enlighten me as to the nature and active principles of the "wild melon," (a species of cucurbitacea which abounds in these parts, as I believe it does also in many others).

The patient, a child of three years old, and of robust constitution, at 11 a.m. was noticed by the parents to be feverish and unwell at the same time that it complained of being "sick." It continued thus for some hours, and once or twice vomited quantities of what was described to me as "watery fluid." At about 4 p.m. the child took "a fit," according to the mother, which closely resembled what she had seen in poisoned

dogs, the back being arched (opisthotonos), the eyes rotated upwards, and foam at the mouth.

I was then sent for, and on arriving found the child comatose, the teeth slightly apart with the tongue pushed against them, the eyes fixed and with "pin-hole pupil," quite insensible to light. Pulse 140; temp. 98°. The face pale and the breathing laboured. A warm bath having been prepared by my orders the child was placed in it, when again it vomited a large quantity of fluid containing the skins of several "melons." I now noticed that the pupils suddenly regained their normal size, and the child cried. The stomach having been fully evacuated and a warm bath administered, the child was laid down again, and again the pupils returned to the "pin-hole" condition, the pulse having come as low as 100 per minute. I then administered two grains of calomel and brandy in 3j doses frequently, and in a short time a profuse perspiration ensued, after which the patient slept for four or five hours, and on awakening seemed perfectly well. Next morning the only remaining sign was a discolouration of the sclerotics with bile.

As I said before, I shall feel indebted to any one who will be good enough to add to my knowledge in regard to this noxious weed.

[*NOTE*.—The Chief Inspector of Stock in Brisbane received information early in May that there had been considerable mortality amongst horses on Monkira Station, Diamantina River, consequent on their having eaten the "wild melon" indigenous to Australia.—*Ed. A.M.G.*]

PERFORATING WOUND OF RECTUM—RECOVERY.

By F. W. MONSELL, L.R.C.S. AND L.K.Q.C.P.I.,
PORT PIRIE, SOUTH AUSTRALIA.

THE following case is of interest for the reason that, in the literature of the subject I find nearly all such severe cases have ended fatally, as also did one case which appears precisely similar, and published by Prescott Hewitt, *Trans. Path. Soc., London*, vol. 1, page 152.

The case is as follows:—

M. W., aged 7 years, while standing on a broken chair slipped and fell in such a manner as to cause one of the supports of the back to penetrate the rectum, tearing through the sphincter, and finally being buried in the areolar tissue around the bowel. When the father tried to lift up the child so firmly was the foreign body imbedded that he lifted child and chair right off the ground. There was no bleeding nor

rise of temperature to speak of, but a good deal of pain and restlessness. Having thoroughly cleansed the wound with an antiseptic lotion I put in two stitches, but there was no sign of healing as the fæces exuded between the stitches, and there was a great deal of trouble from flatus, so I removed the stitches and introduced an india-rubber tube, guiding it past the rent and for about seven inches up the bowel; this allowed escape of much flatus, and by giving a small injection of water each day through the tube which came back by the same channel, carrying with it liquid fæces, and afterwards syringing the wound with carbolic lotion, it began to heal, and finally terminated in a complete recovery.

PROCEEDINGS OF SOCIETIES.

NEW SOUTH WALES BRANCH OF THE BRITISH MEDICAL ASSOCIATION.

THE 89th meeting of the Branch was held in the Royal Society's rooms on Friday, the 2nd May, G. T. Hankins, Esq., M.R.C.S., in the chair. There were present: Drs. McDonagh, Shewen, Lyden, Martin, Jarvie Hood, Knaggs, Pockley, Maher, Quaife, W. J. O'Reilly, Thomas, Crago, Foreman, Rennie, Fiaschi, Hodgson, Wright, Worrall, Sydney Jones, Jenkins, Cohen, Newmarch, Kingsbury, Clark, West, E. F. Ross, De Lambert, Fieldstad, Lloyd. Visitors: Drs. Goode and Nash.

THE PRESIDENT announced that he had received from Dr. Ross (who was unable to attend himself) notes of a case of imbecility, and that the patient was present for examination.

THE HON. SECRETARY then read the following notes by Dr. Ross:—

CASE OF ACQUIRED IMBECILITY IN WHOM THERE IS AN UNDESCENDED TESTICLE.

SHOWN BEFORE THE N. S. WALES BRANCH B.M.A.
By CHISHOLM ROSS, M.D., MEDICAL OFFICER,
HOSPITAL FOR THE INSANE, GLADESVILLE,
NEAR SYDNEY.

FIRST as to the absent testicle. The patient states that he is not sure whether two were ever present, but has a vague recollection of an injury which caused the missing one to disappear. It is probable, however, that the gland has developed and remains still secluded within the abdomen.

Second, he is an imbecile of an interesting class, viz., the acquired as compared to the congenital, the mental want being due to a febrile attack.

It will be observed that his head is unduly small, its horizontal circumference being 19½ inches instead of the average 24½ inches. His

palate is also arched more than is usually seen with normal brain power.

The febrile attack (I have no information of the nature of the fever) occurred when he was five years of age (he is now twenty-one), and although he was said to be of normal intelligence up to the age of five, and had learned his alphabet and was able to count, since then he has been unable to learn almost anything, cannot name the various letters of the alphabet with any certainty or count objects placed in rotation beyond a few figures. The special interest lies in the fact that most congenital idiots or imbeciles are teachable to a considerable extent should the ordinary avenues of instruction, such as seeing, hearing, &c., remain open, whereas in the non-congenital form the various interferences with development, or accidents of which the present is one instance, preclude the possibility of much, if any, improvement. Comely and winsome non-congenital idiots are often seen (this youth is hardly an example) who have intelligence—the intelligence antecedent to the incidence of interference with development—depicted in every feature, but it is unreal, the shadow without the substance, a picture with true colour but no substratum of healthy brain canvas.

The arrest of mental development in this case is fairly complete, but as nearly all idiots or imbeciles possess the mimetic faculty strongly, he has learned to talk freely, to perform the ordinary functions of life, and except for a certain loss of will control, is a useful, well-behaved youth.

DR. GOODE read a paper on tumour of the vulva, the case being that of a woman twenty-five years of age (unmarried), admitted to Sydney Hospital 19th July last year.

Having read the paper, Dr. Goode stated that the tumour (which was exhibited) had been placed in glycerine first and spirits afterwards. As the young woman, on her departure from the hospital, had been instructed to return if anything reappeared, and as she had not done so it was reasonable to suppose that there was no recurrence of the growth. At first the tumour gave him the idea that it was elephantiasis, but when he proceeded to operate he found it was not. The disease and affection had been described in a recent American journal, which contained a very elaborate account of it (with a series of drawings) by a lady doctor. He believed the disease was classed as lupus hypertrophica. He brought the case forward for discussion, and to hear the opinion of the profession as to whether the disease belonged to the class referred to. A section had been placed under the microscope by Dr. Rennie.

THE PRESIDENT thanked Dr. Goode for his notes on the case.

THE HON. SECRETARY (Dr. Worrall) exhibited a small specimen which he stated looked like Dr. Goode's exhibit. He classed it as lupus hypertrophica. Dr. Rennie had stated that under the microscope more cells were noticeable in this exhibit than in Dr. Goode's.

The names fibroma, elephantiasis and lupus hypercrophica seemed to be applied indiscriminately to tumours of the clitoris and vulva. Both clinically and pathologically it was difficult to differentiate these neoplasms. It was desirable to remove all growths of the vulva as early as possible, as the irritation to which they were exposed might probably excite malignant disease. This growth had been removed by the scissors and the thermo cauterium applied, but after the patient had got back to bed the nurse had to apply perchloride of iron in order to stop hæmorrhage.

THE PRESIDENT wished to know whether Dr. Goode had decided the case was not elephantiasis.

DR. GOODE replied that when he made the incision he came to the conclusion that the case was not elephantiasis, as there was no great vascularity about it.

DR. RENNIE said that he had put two sections under the microscope. In Dr. Goode's specimen the tumour was found to be inlaid with fibrous tissue, while in Dr. Worrall's the section had many small cells, the fibres being more widely separated by them. The difference between the two was, in Dr. Goode's case the tumour was firm, hard, and contained many fibres, while the tumour was very much softer in Dr. Worrall's, the cellular element predominating.

DR. ODILLO MAHER read a paper on iridodermis, and exhibited four cases, comprising a brother, sister, and two cousins.

The members having examined the cases,

THE PRESIDENT said the paper was one of the most important read before the Association, illustrating as it did the effects of hereditary tendency. He would like to hear the views of some pathological surgeon present.

DR. HODGSON desired to know from Dr. Maher whether there was any analogy for the absence of the iris in the animal kingdom, and whether it could be traced backwards as an occasional occurrence in man. He would like to know what would be the ultimate effect of the absence of iris. In the case under notice the patient had developed cataract in both eyes, and it would be interesting to have an explanation of the cause, and whether it was usual for cataract to be developed in such cases.

DR. POCKLEY considered that thanks were due to Dr. Maher for bringing these interesting cases before the meeting. They were very rare. He had only seen one case before with absence of iris, and that was kept as a show case in Vienna. He thought Dr. Maher deserved great credit for having worked out heredity in the cases introduced, as in this country it was very difficult to trace heredity or the history of any disease through so many as five generations.

THE PRESIDENT said that cases of iridodermis were extremely rare. The malformation seemed to resemble phimosis in its strong hereditary tendency more than any other malformation. He supposed that malformation was not the only cause of the disease. Dr. Richardson Cross had recorded the case of a woman who had been frightened during pregnancy by a dog on one occasion, and by seeing a butcher stab her servant. She was afterwards haunted by an eye. Immediately the child was born she enquired if its eyes were right, and it was then found that the child had no iris. No doubt if such cases as had been exhibited to-night could be attached to the hospital they would prove of value with regard to the use of the ophthalmoscope.

DR. MAHER replied that the condition was very rare, he had never previously seen a case. He could throw no light with regard to the question of its occurrence in animals, though he thought it possible that animals might suffer as well as human beings. Dr. Hodgson

wanted to know what would be the ultimate effect. He should not think that the child was likely to suffer from any disease further than that she had at present. He thought she was not likely to develop cataract. Excessive light might produce cataract, but he did not anticipate that she would be likely to suffer in this way, or that the ultimate effects would be at all deleterious. Since under his care Mrs. F. had developed cataract very rapidly, but he should not think it probable that other members of the family would be similarly affected.

DR. WRIGHT read a paper on beef tea.

DR. QUAIFFE said for some years he had been in the habit of ordering beef tea to be made on a method suggested to him many years ago by the late Dr. Moffitt. The meat, if possible, to be carefully selected and free from fat, cut up and put into a sausage machine, then passed through in fine fibres, and the whole of the gelatinous portion taken out. The muscle to be put in a vessel in the proportion of a pound to a pint of water and kept cold for three hours. Then to be put on a slow fire and carefully brought to a boil. It should be boiled for a few minutes. If a little toast is used when the beef tea is served up, the shreds could be easily taken. To some extent this method carries out Dr. Wright's directions in the matter of taking out the proteids in the cold water. He, Dr. QuaiFFE, had never tried hydrochloric acid, but the patients who had taken the beef tea as described seemed to derive benefit therefrom.

DR. GOODE had listened with very great pleasure to the carefully-prepared paper just read. The amount of care Dr. Wright had bestowed on the various experiments was deserving of praise. The great difficulty, however, seemed to be in reconciling the conflicting opinions that had been put forward by authorities with regard to the value of beef tea. One authority would say that a quarter of a pound of the original beef was worth, from a nutritive point of view, several gallons of beef tea. Another authority had said that beef tea was useful as stimulating the nerves. It seemed that Dr. Wright considered, with regard to the cold preparation, that the maceration of muscle in water and hydrochloric acid was, in weather of ordinary temperature, an unsuitable product, being likely to go bad and to become poisonous, and that if we boiled our solutions we would get our substances in the form of a precipitate. We could thus make the patients drink the thick and thin. He (Dr. Goode) had no doubt of the value of hydrochloric acid in the cold solution; the proteids could be extracted in the way suggested by Dr. Wright.

DR. SYDNEY JONES remarked that the members were very fortunate in listening to the reading of a model paper, and he was much gratified that gentlemen attached to our medical school, specially engaged in scientific work, were coming forward to give the profession a scientific basis for practical operations. He was pleased to listen to the paper, because it gave one the scientific *rationale* of the preparations which he had been in the habit of ordering for many years. If he was not mistaken Liebig's extract was prepared in almost precisely the same manner as Dr. Wright had recommended. His (Dr. Jones's) practice had been to order one pound of beef finely chopped or minced, all the particles of tissue other than muscle being carefully removed. The muscle is then put into a pint of cold water and a small quantity of acid added to it, say a teaspoonful. The meat should be allowed to remain in the water, as recommended by Dr. Wright, for the proteids to be extracted. But in this climate the cold solution very quickly becomes decomposed and offensive. He (Dr. Jones) had always given directions for the beef to be immersed in cold water, put aside for

four hours, then put into a pot, placed upon the fire and gradually brought to a boiling point, the boiling to be allowed for a very few minutes only. He had been very particular to direct that the sediment should be taken with the clear fluid, and on no account should the sediment be strained off. Such beef tea was most palatable, and he had never found patients offer any objection to taking the sediment with the clear fluid.

DR. WORRALL asked Dr. Wright's opinion on the following method of making beef tea:—A quarter of a pound of best beef finely minced, put into a pint of water and allowed to slowly simmer for three hours with frequent bruising, the whole being then forced through a strainer so that no residue was left, the muscle fibres being thoroughly disintegrated in this way. Both the sapid substances and the proteids were thus obtained, and the pint of fluid would thus contain all the constituents of a quarter of a pound of the best beef.

DR. HODGSON said that he simply gave patients raw beef tea. In many houses it was difficult to get instructions carried out as to the method of preparing beef tea. His practice was to have the beef minced up, and fill a tumbler three-quarters full. It was quite immaterial whether the fat or fibrous tissue was taken away. The tumbler being three-quarters filled with raw beef fill it to the top with water and add salt. This should be left four hours in the cold. In some cases the appearance was reddish, which was sometimes considered objectionable to the sight. To avoid this it should be placed in a cup coloured with burnt sugar, or three drops of Worcester sauce should be added to half-a-pint of beef tea. Under this method the patient partook of the albuminoids. If boiled the dregs were given. He stated that vomiting had been stopped by the use of cold beef tea. It was very important that the beef tea should not be allowed to stand for more than four hours, as decomposition might set in and the patient take poisonous substance.

DR. LYDEN said that Dr. Fothergill in one of his works had stated that beef tea was of no value as a food. It was merely a stimulant, and in order that it should possess value it should be accompanied by farinaceous food, hence the custom of giving dry toast or a biscuit.

The PRESIDENT was of opinion that one of the most valuable points brought out was the exactitude with which calculations had been made concerning the amount of nourishment we give in a pint of beef tea. It was a satisfaction to know that in preparing it in the way mentioned by Dr. Wright we give one-tenth part of the meat. The plan he (the President) had adopted was salt solution, though he thought hydrochloric acid was preferable, the one reason being that the solution of hydrochloric acid might be antiseptic, and render the beef tea less liable to undergo decomposition than with the ordinary salt solution.

DR. WRIGHT said in reply that by the method mentioned by Dr. Worrall the proteids and sapid substances were given, but he thought there would be too much solid matter for the patients to swamp down.

The HON. SECRETARY read a letter from the Hon. Secretaries of the Medical Congress as to the appointment of delegates and date of meeting. Resolved that the matter be dealt with at the next meeting.

The report of the sub-committee appointed to revise Rule 4 was adopted as follows:—"The Council shall consist of a President, Vice-president and eight ordinary members, who shall be elected annually by ballot and be eligible for re-election, provided that the offices of President and Vice-president be not held consecutively for more than one year by the same person. The Hon. Secretary and Hon. Treasurer shall be elected by the Council from members of its own body."

SOUTH AUSTRALIAN BRANCH OF THE BRITISH MEDICAL ASSOCIATION.

MONTHLY meeting, held at the Adelaide Hospital on May 29, 1890. Present: Dr. Cleland (President) in the chair; Drs. Verco, Clindening, Mackintosh, Todd, T. K. Hamilton, Cawley, Cookson, Symons, Lermite, Lawrence, Lendon, Gregerson, Lynch, A. A. Hamilton, Jay, Marten, and the Hon. Sec., Dr. Poulton.

Dr. T. K. HAMILTON exhibited a case of Staphyloma of both Corneae, in which the protrusion in each eye is almost symmetrical as to its position, size and the portion of pupil involved; also a Hydatid mother-cyst, removed from the roof of the back of the orbit after enucleation of the eyeball. Dr. Hamilton said that during the past fortnight two ophthalmic cases and one aural had come under his notice, which were clearly connected with the influenza epidemic.

Case No. I.—A child, aged 12 years, developed a bad eye soon after the onset of the influenza symptoms, and now after her recovery from a rather severe attack of the illness, the following condition of her right eye is observed:—Eye painful, upper lid heavy and inclined to droop, some photophobia and lachrymation, superficial and deep vessels distended; and on careful examination of the cornea by oblique illumination, a small area of very superficial ulceration is seen situated near the centre of the pupillary area. Pupil acts perfectly.

Case No. II.—A rather feeble-looking man, aged 64, was attacked by influenza about 4 weeks ago and had a severe illness, lasting nearly a fortnight. When beginning to convalesce his left eye became affected and has remained weak since. On examination an area of superficial ulceration is found almost in the centre of the cornea, measuring 5.5 x 2.5 m.m. (long axis horizontal), the ulcer is completely anæsthetic, while there is a hyperæsthetic condition of the adjacent corneal tissue; the ulcer does not seem inclined to spread or increase in depth.

These two cases are interesting as corresponding pretty closely with a description, recently published by Galezowski, of two classes of cases of ocular complications observed by him during the influenza epidemic in Paris. He attributes the symptoms to some abnormal condition of innervation, which was the probable cause in those just recorded. Certainly in case No. II, where a central corneal ulceration is developed, accompanied by anæsthesia.

Case No. III.—A lad, aged 12 years, was suddenly seized during the convalescence from influenza, with violent pain in the left ear; this continued for three days, marked by occasional intermissions, until he came under treatment. He was then in great pain, had spent three nearly sleepless nights, and had been delirious the last night. On examination the membrana tympani was found very red and swollen, and apparently bulging; considerable tenderness about the external ear and tenderness and redness over the mastoid. A free incision was made through the posterior part of the membrane, which was followed by complete relief and 12 hours sound sleep. Bronner, in referring to the symptoms he has observed in cases where influenza attacked the middle ear during the epidemic in England, has noticed the intermittent character of the pain, which, however, he found not to yield to incision of the membrane, as it usually does in ordinary cases of myringitis. My experience, as just related, differs from his on this point so far.

Dr. POULTON showed a boy whose elbow he had excised periosteally for disease subsequent to enteric fever.

Dr. MELVILLE JAY read the following

NOTES ON THE INFLUENZA EPIDEMIC.

By MELVILLE JAY, M.R.C.S.E., L.R.C.P., LOND.

Mr. President and Gentlemen,—

In January, 1886, I read a short paper before this Society concerning an epidemic of influenza which prevailed throughout the colonies during the latter part of 1885, and I thought, perhaps, it would be of interest to compare the symptoms met with during that epidemic with those we have all had such a surfeit of during the past few weeks. I am well aware that the subject of influenza is worn threadbare, as it has been discussed and written upon from every conceivable aspect; but as the epidemic has spread over such enormous areas and has, in fact, attacked the whole civilized world, it is just as well that the type of disease should be noted in the various countries affected.

The etiology of the disease is still in obscurity, although there can be but little doubt that it is due to some, at present unknown, micro-organism; and the extensive character and rapidity of infection of the disease point to the development of this bacillus, not only in the persons attacked but also in the atmosphere itself, by which it spreads from place to place. It thus follows that it is highly infectious, but it does not appear to be markedly contagious, as persons in constant contact with others suffering from the disease escape, perhaps to be attacked some weeks later. The atmospheric conditions appear to affect its development and the rapidity with which it spreads; and several articles have been written relating to this atmospheric influence. The disease affects rich and poor alike of all ages.

The period of incubation varies, in some cases being fairly well-marked and lasting from a few hours to about two days; but in the great majority of cases there cannot be said to be any incubatory stage, as the onset of the disease is so sudden. The symptoms of the disease may be summed up as follows:—

- Fever.
- Headache.
- Anorexia.
- Catarrh.
- Prostration.
- Muscular pains.
- Lung complications.
- Gastro-intestinal complications.

As a rule there was a feeling of malaise and depression for a few hours, followed by a period of chilliness, occasionally with rigors. The temperature rose from two to five degrees, but generally subsided rapidly under appropriate treat-

ment and proper attention. In children I had several cases where the temperature remained for several days from 104° to 105° Fahr., accompanied with a considerable amount of delirium, without any lung or other complication to account for the feverish state. Speaking generally, the pulse was rapid and weak in character, occasionally showing some irregularity. The affection of the head, which I consider to be due to involvement of the frontal sinuses, was a most marked characteristic of both this and the epidemic of '85, and was never absent. It was usually accompanied with ocular pain and tenderness, together with an injected condition of the vessels of the eye, enabling one, in a great number of cases, to diagnose the disease at a glance.

The loss of appetite varied, in many cases being unaffected, while in others there was complete anorexia. In both epidemics the prostration, mental depression, listlessness and general limpness—which, I think, expresses the condition most accurately—were distinctive features, and were always present in a marked degree, even in cases where the other symptoms were comparatively mild.

I met with several instances where strong, robust men and women were actually reduced to tears from lowness of spirits, consequent on an attack of influenza. Only those who have passed through a severe attack can form any idea of the prostrating effect of the disease.

In any of the articles written on influenza I do not see that anyone has suggested the cause of this prostration, so totally disproportionate to the severity of the disease. Perhaps it may be accounted for by the effect of the bacillus, the life history of which is apparently much shorter than in the specific fevers, such as measles, small-pox, etc., and, in consequence, the shock to the nervous system is more acutely felt; the rapidity of the changes, whatever they may be, in the system, causing them to be more severe and the consequent prostration greater than in diseases of a similar character. With reference to the catarrhal symptoms, which are commonly looked upon as the main characteristic of ordinary epidemic influenza, the present prevailing epidemic is rendered peculiar, I might almost say unique, by their absence in the vast majority of cases. One naturally associates the term influenza with a condition in which coryza, sneezing and general stuffiness of the head are present, but in at least 90 per cent. of the cases in this epidemic none of these symptoms were to be found. Of course we met with numerous cases of catarrh occurring from a few days to a fortnight, or more subsequent to the onset of the disease, but in these cases one must regard the catarrh as an avoidable accident or

complication of the disease, and not as one of its initial symptoms such as we meet with in ordinary influenza.

The next most noticeable feature of the disease is the extreme muscular pain, especially felt in the lumbar region and spreading down the lower extremities, causing a feeling of weakness and unsteadiness of gait, persisting for several days after the fever has subsided. This condition is felt more or less in all specific fevers, but is certainly more intense in character in influenza.

The lung complications form the most serious feature of the illness. Pneumonia has been the most frequent, and numerous deaths have occurred in South Australia from this cause. As has been observed by various authors the lung inflammation is usually accompanied with pleurisy, and is markedly adynamic in character.

Bronchitis, too, is frequently met with, but is usually more amenable to treatment.

I have only met with a limited number of cases showing at all severe gastro-intestinal complications, but in two young girls the vomiting was so constant and so intractable for several days that I was forced to resort to the use of nutrient enemata. No remedy appeared to have the slightest effect, and even ice, champagne, etc., were all vomited up in a short space of time. One case had slight hæmatemesis, with severe diarrhoea, and the other passed a considerable quantity of blood from the bowel for over a week, accompanied with complete relaxation of the sphincter ani; neither case had any rise of temperature after the second day.

Of rashes the only one I have observed is Herpes Labialis, but I note that papular and roseolar rashes have been recorded, followed by desquamation.

On comparing the symptoms of the present epidemic with those of 1885, I find the chief differences consist in the increased severity and more marked character of the pains of the back and lower extremities in the present epidemic, and in the fact that the catarrhal laryngeal and chest symptoms in the vast majority of cases occur several days subsequent to the onset of the disease, in many cases being entirely absent; whereas in the epidemic of '85 the catarrhal condition, spreading from nose and throat to larynx, chest, etc., was one of the most marked initial symptoms, and, as I then pointed out, in my experience, constituted the main element of danger—I had two deaths from "œdema glottidis."

I have found this difference between the two epidemics so marked that I look upon the chest symptoms in the present epidemic only as a sequela of the original disease, and one that could always be prevented by keeping the affected per-

son in a fairly uniform temperature until all symptoms of his attack had passed away, and particularly until the feeling of depression and prostration had completely subsided, during which he is peculiarly susceptible to cold.

Now the question suggests itself, are those slight differences in the symptoms occurring during the two epidemics sufficient to constitute two distinct diseases? I should say certainly not! It is a well recognized fact that epidemics of any disease have particular characteristics. Take for instance typhoid fever: during one year we may meet with nothing but diarrhoea and in another constipation will be the rule; and so I think we might well do away with the terms Russian influenza, la grippe, etc., and say the world has been visited by an epidemic of influenza, differing only from other epidemics in its vast extent.

One attack does not necessarily protect from a second. I have met with several cases where a person has had two distinct attacks of influenza, with an interval of over a fortnight.

Relapses are frequent, but are usually due to carelessness and exposure to cold on the part of the person affected.

Influenza seems to have a distinct influence on pre-existing conditions. Neuralgic patients who have been free from an attack for years will again suffer after influenza. So I have found with asthma, hysteria and epileptic subjects.

With regard to treatment.—The main element is to nurse oneself and keep in a fairly warm temperature as soon as shivering, lumbar pains, headache, etc., supervene. There is no doubt that the great danger consists in exposure to cold or fatigue during the period of prostration. Quite 50 per cent. of the cases I have met with have resumed their occupations too soon, and contracted chest troubles of a more or less serious character.

As far as drugs are concerned I consider that antipyrin acts as a specific in ten grain doses, as far as the frontal headache is concerned; and I have found salicylate of soda the most useful drug in relieving the lumbar and other pains and in reducing the temperature. Quinine I have not found so useful as the above, except in the later stages.

There is one point connected with the pathology of the disease I meant to have spoken of. Gluge states that in fatal cases of pneumonia connected with influenza he has found in the bronchi exudations very closely resembling the false membranes of croup. Perhaps Professor Watson or some other member of the Society can give us further information on this point.

Dr. VERCO then read a paper on the same subject, as follows:—

THE EPIDEMIC OF INFLUENZA IN ADELAIDE IN 1890.

By DR. VERCO, HON. PHYSICIAN TO THE ADELAIDE HOSP., LECTURER ON MED. AT THE UNIVERSITY OF ADELAIDE, &C.

DURING the month of April there appeared in the suburbs of Hindmarsh and Bowden a few cases of febrile catarrh of an unusual form, which were diagnosed as influenza. The earliest in my practice was of a severe type, resembling very closely an attack of pneumonia, though no physical signs of consolidation could be elicited by repeated examination. My first visit was paid on April 14th. I had, however, been consulted by a lady living in North Adelaide, as far back as March 31st, for an acute catarrh with pyrexia, and had given a probable diagnosis of influenza. If correct, this was the earliest example coming under my notice. I may say, however, that she had an attack several weeks later, so that if the first attack was the real complaint, the second must have been a relapse. From the middle of April onwards, the numbers affected increased rather quickly until about the middle of May, from which time they gradually diminished; although the disease has not yet disappeared.

The complaint was manifestly and eminently epidemic. It came upon the community comparatively suddenly, it abated somewhat rapidly; and during the short period of its prevalence it laid aside an almost incredible number of people. I have been in practice in South Australia now for twelve years, but no other disease, within my memory, has afflicted so many patients within an equal time. The work entailed by the so-called "fog fever" of 1885, reported by Dr. Jay to the Association in January, 1886, was not to be compared to the labour and travail, night and day, necessitated by the visitation of the last two months. From April 14th until the present date I have visited 134 individuals suffering from the disease. Those who came to consult me are not included in this number. So where several patients were ill in a house when I was attending, unless they came immediately under my care and required my treatment they were not registered. Until April 25th only 15 patients were seen, but from April 26th to May 19th, inclusive, 107 new ones were visited. From that date to the present only 12 more have been added to the list. It was, therefore, during the last week in April and the first two weeks in May that the disease raged most fiercely—four times as many patients being

prostrated by it during that period, as in an almost equal period before and since. The whole duration has been only six weeks, and the intensity of it only lasted between three weeks and a month. It may be safely affirmed that, within that month, the persons affected must have numbered tens of thousands in Adelaide and suburbs. It has maintained its character, therefore, as the ideal of an epidemic complaint.

Further, it was a *travelling* epidemic. Its appearance in Dunedin, New Zealand, was first reported at a time when the continent of Australia was free. Then it was recognized in Victoria while South Australia was still enjoying immunity. Shortly afterwards we received news of its existence at Mount Gambier and Bordertown. Next it was detected in Adelaide and its suburbs about the middle of April, and since then it has been reported by "our own correspondents" in the daily newspapers from the districts north and west.

These facts prove conclusively the existence of an epidemic, pursuing a definite course from east to west, with a steady, rapid and fairly measurable pace, so that it would not need any supernatural endowments to predict the invasion of the Western Australian towns at no very distant date. Here we have then a very distinct disproof, and a most emphatic denial of the assertions made in the daily press on the authority of medical men in the city at the commencement of the invasion, that we were dealing with nothing else than the ordinary autumnal catarrhs. Autumn does not travel from east to west at a calculable rate, but this malady did so travel, therefore it could not be the ordinary autumn colds.

This regular extension of the epidemic continuously in one direction indicates also the mode of its spread. If it were transmitted by human contact, or conveyed in postal or commercial packages, it seems difficult to understand why it should appear in New Zealand so long before it did in Australia. There is quite as much postal and commercial intercourse between Australia and England as between New Zealand and the mother country, and almost as rapid communication between Australia and Great Britain as between New Zealand and America. And since the disease broke out in Great Britain before it invaded America, we ought to have fallen victims to it in Australia as soon as, if not sooner than, the New Zealanders. So again, on this theory of contagion by individuals or other fomites, the first evidences should have been detected in Western Australia, which is the first port of call—then in Adelaide, and later on, or almost simultaneously, in Melbourne. But the direction was the reverse of this. Moreover, in

reference to South Australia, when Melbourne was attacked Adelaide was free; but on the theory of contagion carried by individuals or materials, Adelaide would be the most probable place in which infection from Melbourne would be first developed, because the intercourse between Melbourne and our capital is far greater than that of any other town in South Australia. But what do we find? That in Mount Gambier the disease springs up several days before it is detected in Adelaide, that is, in a township altogether out of the direct line of traffic on the intercolonial railway, but situated about midway between the two as regards its longitude. On the theory of a wave of infection, however, passing from east to west, and diffused by the atmosphere, every fact falls into its proper place, and is explained. Passing over New Zealand, and crossing over a thousand miles of sea, it flows over Victoria; entering our colony it involves Bordertown and Mount Gambier, and soon afterwards reaches our capital, and then affects the townships lying to the westward. This then, was the manner in which the infection was probably distributed, viz., diffusion by the atmosphere. A further circumstance in support of this conclusion is that in some cases almost a whole family were affected simultaneously, the father and three children in one day, the mother two days after, as though the same influence had operated upon them all at the same time.

The appearance of the complaint in New Zealand, and its steady passage westward, render it most probable that the epidemic from which we are recovering is identical with that which has swept across Asia, Europe and America, from east to west, and has now nearly completed the circle of the globe, and thus fairly earned the title of a pandemic.

The *onset* was in some instances quite *sudden*. The young man who, last evening, was laughing at his sisters for collapsing under such a trivial ailment, crawls this morning into the doctor's consulting room scarcely able to bear the weight of his own great coat, and with a temperature of over 108°, receives with pleasure the advice to take to his bed at once. Children, playing as though in perfect health in the morning, are in the afternoon prostrate with the fever.

A lady, whose child is ill with the complaint, remarks to the physician in the afternoon that she is a little tired, but does not require his attentions; when he reaches home from his round of visiting the message awaits him to come at once, for the lady is very ill. In other cases the invasion was quite *gradual*, and symptoms were complained of for two or three days before they

attained a severity sufficient to necessitate advice or cessation of work.

The symptoms of *invasion* varied considerably. In no case coming under my care was there any well marked or severe rigour, but sometimes chilliness was complained of, or the sensation of cold water trickling down the back. The most common complaint was a headache, arising rather rapidly, and becoming very severe; sometimes frontal, or occipital, not infrequently general. This was at times so intense as to induce vomiting. The pains were sometimes in the back of the neck; or instead of this in the loins, or in the calves of the legs, or even in the feet as though they were attacked by rheumatism; and in one, a lady who had had rheumatic fever three times, they were distinctly articular, affecting the ankles, knees, wrists, elbows and shoulders, though there was no swelling of the joints or tenderness. They were accompanied by a severe headache, and very trivial bronchial catarrh. Some patients suffered simultaneously in head, back and limbs, and others were attacked in these regions successively, first in the head, then in the back, and then in the limbs; and still others in a different order. In a few instances there was more a sense of weakness than pain. The patient started out for a walk, but had gone only a short distance when the legs almost refused to carry her, and threatened to double up. A marked giddiness might attend the headache, making all movement distressing; and in one case this vertigo and weakness were of such a degree that the patient, while walking in the house, suddenly collapsed and fell to the floor in a sort of swoon, and thereupon took to her bed, where she remained for a week, with pyrexia and bronchial catarrh. A general respiratory catarrh ushered in a few cases, beginning with coryza, or pharyngeal, or bronchial congestion; but this was unusual; and these generally arose gradually afterwards. In one instance, the first symptom was an intense pain in the stomach and bowels, causing the patient to faint, and succeeded by purging with bloody stools, lasting for a day, attended by pyrexia and followed by febrile bronchial catarrh. The initial pain in the loins came on sometimes quite suddenly, as though from a rick in the back, and was occasionally throughout the attack very like lumbago, increased by every movement of the part.

The symptoms manifested throughout the course of the disease exhibited great variety; so that one might almost imagine he was dealing with different complaints; but their occurrence in members of the same family, almost at the same time, precluded such an idea. Headache was one of the most constant symptoms, so

severe as to prevent sleep for two or three nights. This might be attended or followed by a distressing backache; and these two, with pyrexia, might constitute the whole complaint. This headache was not the heavy frontal fulness so well known in nasal catarrh, and supposed to be due to affection of the frontal sinuses; nor did it bear any sort of relation to the catarrhal symptoms; in fact, it was pronounced in cases where these were wanting throughout. It was so intense that the sufferers feared it would distract them. Where bronchial catarrh was present, it greatly aggravated the cephalalgia, because the coughing "shook the head," to use the lay expression, or more correctly, disturbed its circulation. Some ocular pain, as though the eyes were "balls of pain," was now and then complained of. Delirium was not present in adults, but among children it was frequent and noisy, though it lasted only a night or two. The whole attack among children was usually mild, and if the fever was high its duration was short, and they did not subsequently manifest the weakness and prostration often so protracted in their elders. Pains in the bones of the face, in the bridge of the nose, with aching of the teeth, were present for several days during the persistence of the fever, and subsided with it, or might last several days after the pyrexia had disappeared. The bones might be tender on pressure. This condition was quite distinct from the trigeminal neuralgia, and was unattended by any special tenderness at the foramina of exit of the branches of the fifth nerve. Although some coryza might co-exist, and even sanious discharge from the nostrils, suggesting a dependance of the pain upon inflammation of the lining of the nose and antrum of Highmore, yet its occurrence, when there was scarcely a sign of coryza, indicates that it is a true "bone-ache," at least sometimes. This aching of the facial bones was, in one instance, somewhat periodic, increasing after the mid-day meal each day.

Catarrh was very common, but still not nearly so frequent as one had been led to anticipate from the synonym of influenza, viz., epidemic catarrh. In a number of cases there was no sign of catarrh of the respiratory tract from first to last. In many others there was only a slight affection of the bronchi, with or without some sore throat from pharyngeal irritation, and coryza from nasal catarrh was exceptional. Not once, I think, did I have occasion to order a gargle for a sore throat. A few cases had well marked affection of the nose, throat and chest, with nasal discharge, sneezing and cough. The bronchial discharge was by far the most common manifestation of catarrh, and this was not infrequently severe;

the cough being very tormenting, paroxysmal, dry and straining, with but little mucus, tenacious and sometimes rusty. In two or three cases, in elderly people, the symptoms merged into attacks of subacute bronchitis, which confined them to their beds for over a week, and to their rooms for a week more. The cough sounded loose, and as though a good deal of sputa should be raised, and still very little phlegm was brought up; and on listening to the chest only scanty sibilant rales were audible. The nasal and conjunctival catarrhs were most disappointing; they were so rare and so mild. There was not one case that could compare with an ordinary attack of measles. In one case distressing vesical catarrh arose early, causing frequent and irritating micturition, day and night, for twenty-four or thirty-six hours.

The *pyrexia* was as high as 104° F. in some instances, and was noted at all temperatures between that and the normal. The height of the fever did not appear to bear any definite relation to the catarrhal or the nervous symptoms; in fact, with smart pyrexia, there were several times no traces of implication of the mucous membranes; on the other hand the pains and distresses were occasionally severe, yet the temperature was not even above the normal. The highest temperature, however, recorded, was where severe bronchitis was present with abundant herpes and rusty sputa, and pains in the sides of the chest, but in which no physical signs of pneumonia could be detected. The *duration* of the pyrexia varied. It cannot be stated exactly, because the medical man rarely sees a case at its inception; but some certainly did not last more than three days, whereas others were above the normal for over a week. The return of the temperature to its natural level, however, did not by any means always indicate the cessation of the influenza, the headache often persisted for a day or two more, while the catarrhal distresses were frequently as severe as during the height of the pyrexia.

The *pulse* generally rose somewhat while the pyrexia was present, but was usually not very rapid. The rate was as high as 140, even with a temperature of only 101°, and without any marked distress. During convalescence it was often soft and weak, and sometimes intermitting and irregular.

The *appetite* was generally impaired or totally lost. In a few cases it remained good; and one patient remarked that the best thing about the disease was that a man could eat well; and his principal was laid aside in the same institution at the same time, and the medical comforts and delicacies were divided between them, he recognized in the influenza quite an endurable complaint. *Vomiting* was occasionally one of the initial symptoms, and seemed to be due to the

severity of the headache. It very rarely arose during the course of the complaint. The *tongue* was most often thickly furred, moist and flabby. The *bowels* were constipated, though once dysenteric diarrhoea constituted the symptom of invasion, and in another arose during the height of the fever. In this instance it followed upon, and was probably due to, the indiscretion of the patient, whose back was aching so insufferably that she rose at midnight and sat in her dressing gown in an easy chair until the next morning. A mild attack of catarrhal jaundice occurred once, with nausea, anorexia, general icterus and biliary urine, passing off in a few days.

The only *eruption* noticed was herpes, and this was in a very small proportion of cases. It was sometimes confined to the margin of the nostrils, at others both nostrils and lips were affected; in one it affected also the inner half of one upper eyelid; in one the whole muco-cutaneous circle of the mouth was involved, as well as the front of the hard palate, making mastication very painful. The extent of the eruption bore no definite relation either to the height of the fever or to the severity of the catarrhal symptoms, although I did not find it present in any patient in whom catarrh was altogether absent.

Supra-orbital neuralgia was met with three times: once on the right side, once on the left, and once on both sides. In all there was extreme tenderness on pressure at the supra-orbital foramen, and some tenderness at the infra-orbital and mental on the same side. In one it began on the seventh day after invasion, and was continuous; in a second about the seventh, and in the third on the sixth day. In the last two it was intermittent, just like a "brow ache," coming on every day about ten o'clock, lasting in one case for two hours, and in the other for four hours. It was so intense as almost to drive the patients out of their minds. It disappeared after four or seven days.

One very remarkable and fairly constant circumstance was the weakness experienced on attempting to get about after the attack. Frequently there was vertigo which persisted for several days, and was excited by only very moderate exertion; or the back or legs were painful, stiff or weak. This weakness and prostration were in many cases very noticeable; the patient was quite indisposed to leave the bed for days after all pyrexia was gone, and were altogether out of proportion to the mildness and shortness of the acute symptoms. This general weakness and irritability of the mucous membranes remained for a very long time, and some patients who were ill a month ago have not yet recovered their former vigour.

Relapses.—It is difficult for me to speak about the frequency of these, because in most instances their occurrence was outside the observation of the medical attendant. But several times there was a very definite intermission of the pyrexia after two or three days of fever, the temperature falling to normal. The next day the fever returned to its previous height and lasted two days more, being sometimes associated with an exacerbation of the bronchial catarrh and sometimes not.

Complications were very few. In one case, diagnosed as influenza, with a temperature when first taken of 104°, and severe headache and rusty sputa, abundant albuminuria was detected on the second day, with right pleuro-pneumonia two days later. Death occurred the next day, with the delirium of collapse. In this case the nephritis was probably of some months duration, as the patient had suffered from considerable oedema pedum, and if the initial symptoms were those of influenza it was most likely, only the exciting cause of the pneumonia which was predisposed to by the nephritis. In two elderly people smart attacks of bronchitis were induced, originating during the pyrexial stage, and confining them to their rooms for two or three weeks afterwards. Acute pneumonia of the left lower lobe arose from exposure in a young man; it ran a perfectly typical course, and terminated in recovery. Acute pleurisy over the right lower chest developed late in the course of the disease in a young woman, the temperature ranging between 104° and 100°. She is still in the acute stage.

The above enumeration of the symptoms of the epidemic in South Australia, if compared with the published reports of the disease in England, will make evident their absolute identity. There cannot be the slightest doubt, it seems to me, upon this point.

Treatment.—There was nothing very special in the treatment adopted. During the pyrexia the patients were confined to their beds, and after that were allowed to follow their inclination, being only restricted to a warm room so long as they were suffering from bronchial catarrh. If no special symptoms were present they were given saline diaphoretics, and sedative and demulcent expectorants if cough existed. For the severe headache antipyrin was used in fifteen grain doses with advantage, or bromide of potassium. Occasionally I administered sulphonal tablets in five grain doses every hour until sleep was induced. When the pains were articular salicylate of soda was given with considerable relief. In the supra-orbital neuralgia both quinine and hydrate of croton-chloral appeared to diminish its severity; but in all cases it had existed several days, and might have been about to decline spontaneously.

The Hon. Sec. read for Dr. BICKLE, in his absence, the following

REMARKS ON THE INFLUENZA EPIDEMIC IN AND AROUND MOUNT BARKER.

By L. W. BICKLE, L.R.C.P. LOND., M.R.C.S.E.

THE wave of the epidemic of influenza which has spread so widely over the Australasian Colonies has not spared this district. For the extent of population its distribution would seem to be quite equal to that of Adelaide. Very few houses have escaped from its visitation in some form or other, and though fortunately the mortality direct or indirect has been very low, yet in many cases very considerable anxiety has been caused by the gravity of the complications.

The most striking feature in the epidemic has been the absence in the great majority of cases of the coryzal symptoms one is accustomed to associate with the term influenza; after the fever and pains have subsided there has been very free and copious expectoration, in many cases without cough, although in the majority of cases very persistent and troublesome cough occurred, and with the cough, and independently of it, that delightful condition known as a "stuffed nose."

The onset and duration of the complaint has been very various. This has been particularly so in the case of children; in fact so different was it in some of the first cases that I was disposed to regard it more as a febrile gastric derangement than influenza, but the number and similarity with the fuller development of symptoms in others led me to alter my opinion, and I now regard them as one and all manifestations of the epidemic. In many children the condition was this: high fever (103 to 104°), severe headache, very flushed face, nausea, constipation, a very offensive breath, and furred tongue. The treatment was simple: rest in bed, fluid food, small dose of Hydrarg. Subchlor., followed by a saline mixture of the Sulphates of Magnesia and Soda in the shape of *Æsculap* water, and the next day the children were comparatively well. In one case, a child of three, the attack was ushered in by a convulsion, many of the symptoms making one fear a pneumonia was coming on; then came severe headache and prostration, and following that cough and the characteristic debility left by the complaint. Another case ushered in by convulsions in a young child has just come under care.

In the case of adults there has been usually a period of invasion characterized by pains in the limbs and general malaise, with a sudden onset of the acute symptoms generally in the shape of headache of a most intense and prostrating

character, to which is added severe pain in the back between the shoulders, pains in all the limbs, and a sensation as of cold water being poured down the back; in many cases this was accompanied by fever ranging from 101 to 104.5°. The headache lasted from 24 to 48 hours, leaving the patient comparatively well but feeling very weak, or in less favourable cases followed by numerous sequelæ and complications; and of these the large majority were caused by a too light regard for the original attack, leading to exposure to cold and its effects.

One of the minor symptoms from a dangerous point of view, but by no means a light one from a point of comfort, has been the fearful taste complained of—a taste that could both be “smelt and felt;” in one case in particular it was suggestive of gangrene of the lung.

The *throat* has been a great source of trouble, in most cases very congestive and the uvula cedematous, and undoubtedly strongly conducing to the persistent cough. In one case in particular it was so brawny and infiltrated that the necessity for scarifying it was discussed.

The *lungs* have been, as would be expected, a considerable source of trouble, bronchitis, pleurisy, congestion, and inflammation have all had their victims. By congestion I mean a condition in which there has been distinct impairment of resonance, crepitation on inspiration and impaired movement of the lung affected, but clearing up at the end of 36 or 48 hours without going on to the condition of marked tubular breathing and absolute dullness.

The *abdomen* has contributed its share. There have been cases of undoubted gastric and intestinal catarrh. In several instances the onset of this relieved the lungs, and on its subsidence the chest symptoms returned. In several cases very severe abdominal pains were complained of, and in these there was usually special pain referred to the liver, which was acutely painful when the hepatic region was examined. The splenic region was also tender to touch, but much less so than the liver.

The *nervous system* has yielded several cases of very severe facial neuralgia, following the acute attack, in some cases preventing the jaws from being fully opened for two or three days. Two or three cases of supra-orbital neuralgia, in one case with herpes of the 5th nerve. In a few cases sciatica has followed, in one or two cases inducing a first attack, in others causing a return of an old malady. Rheumatic fever has followed in at least three cases—in one there have been repeated attacks in former years, in the other two a first attack has been induced.

In one case of pregnancy a sharp attack was followed by premature labour at the seventh month, but it can scarcely be fully charged to the attack of influenza, inasmuch as there had been a smart hæmorrhage three weeks previously, and the pregnancy was a twin one. It is, however, worthy of note, in view of the prostrating effects of the influenza, that although the placenta were adherent in nearly their whole extent, and requiring considerable manipulation to separate them, no septi: trouble followed, and the mother made a good recovery.

With regard to treatment—the most important feature in the minds of the laity at all events—there seems to be great diversity. If the advertisements of the papers are to be believed, and were acted upon, it is pretty certain that the doctors would not have been run off their legs. The complaint is, undoubtedly, amenable to the action of several drugs, in particular quinine, salicylate of soda and antipyrin. The old-fashioned but very useful diaphoretic saline (Vin. Ant. Tart., Spt. Æth. Nit., etc.) preceded by a calomel purge in the cases in which it was used proved very effectual. Another prescription I found to cut short the pains very rapidly consisted of:

Q. Sulph. gr. ij, Acid Hydrobrom: Dil m ×
Liq. Ammonia Acet. 3ij. Liq. Papav. Alb. 3i
Aq. ad 3j 4 tis. horis.

The salicylate of soda, in conjunction with sod: bicarb. and tinct. cinctionæ., formed another good combination, and antipyrin, when used, was of marked service.

The sequelæ and complications were treated on general principles. The hepatic pain and tenderness noted previously yielded to nothing so promptly as the old time-honoured Cal. c Ialapæ.

These are briefly the main points that present themselves for me to notice. I regret that I cannot get down to personally take part in so interesting a discussion. Perhaps if I could you might have been spared a certain amount of the repetition that must necessarily occur, as in writing one will probably traverse ground already covered by previous speakers.

One other point I had almost forgotten: so prevalent has been the disorder that every ache and pain has been referred to influenza, and sometimes with serious results. One case diagnosed by the friends as influenza when seen proved to be rheumatic fever, in which, unfortunately, a systolic murmur had developed during the week of self-treatment. In another instance the so-called influenza turned out to be a well-marked case of enteric fever. It is only fair to add that both of these cases were several miles from the township.

An interesting discussion followed, in which the President, Drs. T. K. Hamilton, A. A. Hamilton, Cookson, Todd, London and Verco joined.

Dr. Clindening gave a very graphic account of an attack of influenza, from which he had recently recovered.

Dr. CLELAND stated that at the Parkside Lunatic Asylum 8 of 60 attendants were attacked, and 20 insane people out of 565 inmates were noted as suffering from influenza.

THE WESTERN MEDICAL ASSOCIATION OF SYDNEY.

A MEETING of the above Association was held at the School of Arts, Ashfield, on May 16, when the rules and by-laws were discussed and finally adopted.

The following gentlemen have been elected honorary members of the Association:—Drs. Brady, Blaxland, Bott, Chambers, W. Chisholm, Clubbe, M. Clune, Creed, Crago, C. Dixon, T. Dixon, Eichler, Ellis, Evans, Faithfull, Fiaschi, Foreman, Fieldstad, H. E. Garrett, Graham, Hankins, Hood, Hughes, Jenkins, Knaggs, Kyngdon, Manning, MacCormick, MacLaurin, Miles, Morton, Norrie, Patrick, Piercy, Philip, Pockley, Purser, F. H. Quafe, W. F. Quafe, Rennie, Simpson, Ross, Schwarzbach, Scot-Skirving, Shewen, Professor Stuart, Thomas, Twynam, W. D. C. Williams, Worrall, H. G. A. Wright.

The President of the Association, Dr. MacSwiney, has been appointed to represent the Association on the Executive Committee of the third session of the Inter-colonial Medical Congress of Australasia, to be held in Sydney in 1892.

LEPROSY IN AUSTRALASIA.

FROM a report of the New South Wales Board of Health respecting the prevalence of leprosy in the Australasian colonies, prepared from information supplied by the boards of health and other authorities in the various colonies, we learn that the total number of lepers under official cognizance at the close of 1889 was 30, of whom 12 were in New South Wales, 4 in Victoria, 2 in South Australia, 6 in Queensland, 1 in West Australia and 5 in Fiji. As to the nationality of the persons it is stated that 2 are natives of New South Wales, 20 of China, 1 of Java, 2 of Fiji, 2 of New Hebrides, 1 of the Solomon Islands, 1 of Malacca, and 1 of the Straits Settlements. Thus, with the exception of two cases in New South Wales, all the sufferers belong to dark-skinned races—Chinese, Javanese, or South Sea Islanders. "The tuberculated or nodulated and the anæsthetic or macular forms of leprosy are represented in about equal proportions. Besides the persons under direct enumeration it would appear that in some of the colonies there are others of whom no account is taken. In a report from the Chief Medical Officer at Fiji it is stated that in addition to the five under Government care 'there are cases—almost all of the macular or anæsthetic type—among the aboriginal race of Fiji, who are to a limited extent segregated by the order of the native district chiefs,' and the Under-Secretary of the Colonial Secretary's Office, New Zealand, in reporting that there are no hospitals for the special treatment of leprosy patients and no lepers under treatment in any hospital, states that 'the disease is not absolutely unknown in New Zealand.' There is indeed reason to believe that it exists in several districts among the native race, the sufferers being kept somewhat apart from their fellows within the boundaries of the native paha." In Tasmania alone the disease appears to be

unknown. After referring to the manner in which the lepers in the different colonies are isolated the report points out that in New South Wales, New Zealand, Queensland and Fiji there are no laws or regulations in force dealing with lepers.

As to the cases in New South Wales the report contains the following particulars:—

"Of the cases under care in New South Wales two were admitted in 1833, 1 in 1885, 3 in 1886, 1 in 1887, 4 in 1888, and 2 in 1889, and of the Asiatics the majority developed the disease in periods varying from six months to four years after arriving in the colony. In one case however, six years, in another seven years, and in a third ten years, elapsed between the time of arrival and the appearance of leprosy.

"The occurrence of the disease in persons of European extraction is a matter of very considerable interest, especially in view of the fact that in addition to the two cases now under care a case of death from leprosy in a man of European parentage was reported to the board by the City Coroner during the year 1889. In this case the death was certified as due to leprosy by two medical practitioners, one of whom saw the patient repeatedly during life, and there appeared no doubt as to the accuracy of the diagnosis. The individual had never been separated from his family or specially isolated with them, and there is reason to believe that there are several other cases in the colony not in any way isolated and under no official cognizance or care."

"Particulars of the two cases in persons of European extraction, taken at the date of the cases being reported to the Board of Health, are given in the appendix to the report, from which it is seen:—1st. That the patients are natives of New South Wales, and have never been out of the colony. 2nd. That they are both sons of persons of British extraction, who were either born in or have spent all their lives in the colony. 3rd. That they are members of large families, none of the others of whom are affected with leprosy, and that there is no evidence of the disease being hereditary. 4th. That they have always been in a position to obtain a full and varied dietary. 5th. That the disease existed in one for eight years, and in the other for four years, before report was made to the Board of Health and the patients isolated. 6th. That in both cases there has been communication with the Chinese, and though there is no satisfactory evidence that this communication was other than of a very casual character, there is some reason to believe that in one of the cases it was of an intimate nature."

PROCEEDINGS OF THE COLONIAL MEDICAL BOARDS.

The following gentlemen, having presented their diplomas, have been duly registered as legally qualified Medical Practitioners by the respective Boards:—

NEW SOUTH WALES.

M'Leod, James, M.B. et M.S. Univ. Edin. 1887.
Wright, Almoth Edward, M.D. Univ. Dub. 1889; B. Ch. Univ. Dub. 1883.
Hart, John Wesley, M.B. et M.S. Univ. Edin. 1890.
Neill, Leopold Edward Flood, M.B. et Ch. M. Univ. Sydney 1890.
Purser, Cecil, M.B. et Ch. M. Univ. Sydney 1890.
Hollis, Leslie Thomas, M.B. et Ch. M. Univ. Sydney 1890.

Additional Registration:—

Wilson, Colin George, Ch. M. Univ. Sydney 1890.
Morton, John, M. Ch. Univ. Sydney 1890.

TASMANIA.

Foster, Albert Ernest, M.R.O.S. Eng. 1883; L.S.A. Lond. 1884.

NOTICE.

The Editor will feel obliged by any gentleman, who wishes to ventilate any subject of professional or public interest, writing an editorial or leading article on it, which if found on perusal to be consonant with the policy of the paper, will be inserted in an early number.

All communications intended for the Editor should be sent to the 'A. M. Gazette' Office, 35 Castlereagh Street, Sydney.

** * Contributors can have their Papers reprinted and published in Pamphlet form, at Cost Price, if the necessary instructions are given to the Publisher at the same time the contributions are sent in.*

AUSTRALASIAN MEDICAL GAZETTE.

SYDNEY, JUNE 15, 1890.

EDITORIALS.

THE MANAGEMENT OF THE BRISBANE HOSPITAL.

It will hardly be credited that in a city of eighty thousand inhabitants the patients in the Brisbane General Hospital are under the sole treatment of the Resident Medical Staff, which consists of the Medical Superintendent (who has also the general management of the house and grounds), and the Resident Medical Officer. In an institution containing close on two hundred beds we doubt if two men, no matter what their ability and skill may be, can attend to accidents, in-patients, out-patients, overlook the general management of the hospital, and do justice to the sick and to their other professional duties. It appears that there is an Honorary Consulting Staff and an Honorary Visiting Staff also; but four years ago the Committee thought proper to alter the by-laws, so that the Visiting Staff were relegated to the position of consultants with the right of operation. This alteration was made without the attention of the Visiting Staff being specially drawn to it, and until lately some of them were in absolute ignorance of its existence. With the view of testing this law one of the visiting physicians, who also has the honour of being President of the Medical Society of Queensland, wrote a letter to the Committee stating that as his name was placed over a certain number of beds in the hospital, and as the patients in those beds were not under his care but by the by-laws of the institution under the treatment of the Resident Staff, he would be glad if the Committee would remove his name as soon as possible. This was done, and there the matter ends for the present.

Is it to be conceived that the committee of a metropolitan institution of this kind are so ignorant of hospital management as to allow such a state of affairs? Are the public so blind to their own interests as to passively acquiesce in such an arrangement as not to see the dangers to which it leads. A month ago a man suffering from erysipelas escaped from a tent in the grounds in a state of delirium, went home in the night, and died. A few weeks previously an enquiry was held on a woman who died some time after leaving the institution, and it was stated that when she left the hospital her head was covered with vermin. Would such a state of things have occurred if visiting physicians and surgeons had charge of their patients? Is this management? Rather it is the inevitable result of leaving so much work to be done or not to be done, as the case may be, to two resident medical officers. As medical men we know that residents in hospitals as a rule are young men not long qualified, who are anxious and willing to learn their work; but to place two resident medical men, who are debarred from private practice, in sole charge of a hospital in a metropolis which contains between fifty and sixty practising medical men, is bad for the hospital, the patients, the public, and the medical profession throughout the colony. Was it such a state of things as this that produced a Paget or a Jenner, or coming nearer home, a Fitzgerald or a Fortescue?

If the Committee are alive to the interests of the hospital and the public they ought at once to make a much needed alteration, for the present arrangements, to say the least of them, are in our opinion not wise.

THE OVERCROWDING OF THE PROFESSION IN AUSTRALIA.

FOLLOWING up our article of January, 1887, we again feel it our duty to warn practitioners in older countries not to think that Australia is still the Eldorado for medical men it once was. The number of medical men in the Australasian colonies is now very great, and as a consequence professional competition is perhaps even more severe than in Europe and the United States. As a proof of this, we may say that there were recently 78 applications by properly qualified men for an appointment of resident medical officer to the private hospital of a single mining company, the successful candidate being a practitioner already locally resident.

PROSECUTION OF PSEUDO-PRACTITIONERS.

THE two cases we here report are of much interest as showing what power is possessed and exercised by the Medical Boards of Victoria and Queensland for the protection of the public from imposition by ignorant pretenders. Had these men followed the example of many more cautious quacks, and confined their proceedings to New South Wales they might, as is done by others daily, have carried on their fraudulent proceedings with impunity.

The first case was heard at the Fitzroy Police Court (Melbourne) on Monday, the 19th May, when G. H. Raymond was proceeded against for a breach of the Medical Practitioners Statute. The prosecution was laid under the 11th section of the statute. The information set forth that the said G. H. Raymond, of No. 76 Nicholson-street, Fitzroy, not being registered under the Medical Practitioners Statute, or any act repealed by such statute, did unlawfully pretend to be a doctor. Mr. Nankivel prosecuted. Alfred R. Bremner deposed that his attention had been directed to an advertisement of Raymond's, which ran as follows:—"Dr. Raymond's unrivalled success in the treatment of deafness and all diseases of the eyes, nose, and throat, may be attributed to his proficiency as a general physician, without which a man's success as a specialist would be very small indeed." Since the issue of the summons the witness had received the following letter from the defendant:

SIR,—I am in receipt of your miserable piece of blue paper, and desire to inform you that I appreciate the compliments, and trust when we meet on Monday next you will come prepared with your text books on pathology and therapeutics, which subjects you, like the faculty, know nothing about. I would also inform you, in the most delicate manner imaginable, that I am proof against all the nasty insults you or your ignorant backers might bring under my nostrils, and would add, just by way of reflection, that the game is too shallow to produce any effect.—G. H. RAYMOND, M.D., oculist, aurist, &c.

John Reilly, an inquiry agent, said that on the 18th inst. he paid a visit to the defendant, at his place in Nicholson-street. He told the defendant that he wished to consult him, because there was something wrong with his ears, and he also pretended to be slightly under the influence of drink. Raymond examined his ears and throat, after which witness paid the defendant 10s., and received from him the subjoined written statement:

You have too great a determination of blood to the head, pressure on carotid arteries, obstruction of en-

tachian tubes, and general constitutional disturbances. My fee is £9 per month for treatment and attendance, and if you continue second and third month will charge you £8. You must desist drinking any more alcohol, or you will go irremediably deaf for life. I feel confident I can benefit you with a full course of medicine and local treatment for the ears.—G. H. RAYMOND, M.D. Received 10s. for advice and examination. Hours, 10 a.m. to 12.30, and from 4 to 5 in the evening. You have collapsed drum of ear tubes, from throat to ear obstruction, and pressure on the carotid arteries.

The defendant then went on to say that the witness should be very careful what he drank, as his constitution was in a very precarious state.

The defendant was fined £10, with £2 2s. costs.

The other case was that of T. H. Ennis, who was charged at the Rockhampton (Qu.) Police Court on the 20th May with practising as a duly qualified medical practitioner at Rockhampton, when he was not legally qualified. Mr. Lyons, who appeared for the defendant, said that the defendant had to plead guilty to the charge, but desired to explain that the letters "M.D." only signified "money down," and had no other meaning. The other letters "F.R.S." he could fully explain, as they stood for "Fosterer of Real Science," and the defendant had several other initials which he advertised, viz., Q.H.B., Queensland Herbalist Botanist; and L.C.B.G.M.Q., which represented "Late Curator Botanical Gardens, Maryborough, Queensland." As a matter of fact he had been Curator of those gardens at Maryborough. He (Mr. Lyons) hoped the Bench would remember that the defendant had, in practising the herbalist business, effected cures and done good, besides the defendant was a man with a family. Mr. W. Thompson said that Dr. Callaghan was simply prosecuting under instructions from the Medical Board at Brisbane, who had laid information in the case. The Bench said: Well, Mr. Lyons, we consider that the defendant has only aggravated the offence by the instructions he has given. It must be apparent to any man in the town that the defendant was trying to pose as a medical man; it amounted to a direct insult to the Bench to put forward such an explanation as the defendant had given instructions to do. The whole thing was absurd. The defendant would be fined in the full amount—£20, and the costs, £8 9s. 4d., would be allowed out of that, and three days given to pay it, or levy and distress, and in default of payment six months' imprisonment. Mr. Lyons said that the defendant had been guilty of no crime against the public; but on the contrary had done good with his herbs. Mr. Ranking, in reply, said he knew of one case that was sent to him, and the man went away to die.

IMPERIAL MEDICAL ACT OF 1886.

APPLICATION OF PART II TO COLONY OF NEW SOUTH WALES.

IN the New South Wales *Government Gazette* of the 6th June the Minister of Education published the following Order, made by Her Majesty Queen Victoria, with the advice of Her Privy Council, under which the Second Part of the Medical Act of 1886 is made to apply to the Colony of New South Wales :—

“Whereas by the Medical Act, 1886, it is provided (amongst other things) that Her Majesty may from time to time, by Order in Council, declare that the second part of the said Act shall be deemed, on and after a day to be named in such Order, to apply to any British possession, which in Her Majesty's opinion affords to the medical practitioners of the United Kingdom such privileges of practising in the said British possession as to Her Majesty may seem just, and that from and after the day named in such Order in Council such British possession shall be deemed to be a British possession to which the said Act applies, within the meaning of the second part thereof, and that until such Order in Council has been made in respect of any British possession, the said second part of the said Act shall not be deemed to apply to any such possession.

“And whereas Her Majesty's Colony of New South Wales, in Australia, is a British possession within the meaning of the said Act, and affords, in Her Majesty's opinion, to the registered medical practitioners of the United Kingdom such privileges of practising in the said Colony as to Her Majesty seem just.

“Now, therefore, Her Majesty doth hereby, by and with the advice of Her Privy Council, order, direct, and declare that on and after the first day of April, 1890, the second part of the Medical Act, 1886, shall be deemed to apply to Her Majesty's Colony of New South Wales in Australia.”

The effect of this order is that the medical degrees granted by the Sydney University are recognized in the United Kingdom, and that anyone who has obtained a recognized colonial diploma can be registered as a medical practitioner in the United Kingdom without examination. This privilege, which has recently been granted also to the colony of Victoria, has formed the subject of negotiation on the part of the Medical Board of New South Wales and the Sydney University for the past year or so. The University authorities were naturally anxious that their M.B., Ch.M., and M.D. degrees should

be recognized at home, and their efforts to obtain this concession were backed up by the Medical Board with the result that the desired Order in Council has at last been made. The order does not, of course, affect the position of the unregistered practitioners in this colony, but it will have the effect of enabling any foreign practitioner registered under the provisions of the Medical Act to demand registration in this colony.

DR. KLEIN'S RESEARCHES.

By private advices we learn that the forthcoming report of the Medical Officer of the Local Government Board (England) will contain an account of experiments performed during the past year by Dr. Klein, touching the relations of diphtheria to milk supplies. Dr. Klein has, we believe, got proof that the inoculation of diphtheria-exudation on the shoulder causes a vesicular eruption on the udder in milch cows ; it produces also fever and pneumonia, but not diphtheria. Inoculations made with lung-juice and blood of cows thus infected yielded negative results ; but successful cultivations were made with their milk, and diphtheria resulted in cats inoculated from the cultivation, while hens remained unaffected. The general outcome seems to be that the poison of diphtheria inoculated at a distant part of the body causes a special eruption on the udder among other symptoms, and that the milk secreted by the gland there has infectious properties. These results are of great interest and importance, and in connection with them Dr. Klein's experiments in scarlet fever (in connection with the Hendon outbreak near London) naturally come to mind. He thought it probable, it will be remembered, that the poison of scarlet fever could produce in the cow a constitutional disease, and especially an udder eruption ; and although his reports and experiments were disputed (mainly by veterinarians, and chiefly by those of the Scotch school), they remain still for corroboration, or for rational explanation on some other grounds than those assigned by him.

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"CHLOROFORM V. ETHER."

BY EDWARD J. JENKINS, M.D. (OXFORD),
M.R.C.P. LONDON.

THE attention, both of the profession and of the public, has been lately drawn to the dangers following the administration of chloroform, and the object of the present article is to put before the readers of *The Gazette* the opinions of the leading medical men of various countries as to which is the best anæsthetic at present known for general use. That we have no ideal anæsthetic is quite certain; all drugs that abolish consciousness and reflex action tend, when pushed too far, to paralyze the respiratory centres, the heart, or both, and so causes death. Of the two invaluable agents, chloroform and ether, the question to be solved is this, "is ether safer than chloroform?" if it is, ought chloroform, as some maintain, to be struck out of our list of anæsthetics. That both drugs are dangerous when employed in inappropriate cases is known to all. Each is useful in its own proper sphere. Ether, the less powerful, the most inconvenient, and most unpleasant in its after effects, is, doubtless, safer in the hands of the inexperienced. Chloroform, the most potent, most pleasant, most convenient, and least dangerous in its after effects, is probably as safe as ether in the hands of an experienced, watchful administrator. There seems to be a somewhat general belief that chloroform is hardly ever used by our American brethren. It will be seen, however, that though ether is the favourite anæsthetic in the United States, nevertheless many of the most eminent Americans still prefer chloroform, and that ether has some of its most ardent admirers in Great Britain. It is not my intention to enumerate the advantages or disadvantages of either drug—to state the cases where one should be used and the other avoided—to enter into their physiological action, to describe the methods of administration, or the treatment of serious symptoms when they arise—with these matters we are all familiar. Those of us who are daily using one drug or the other, or both, must have formed an opinion as to which is the most convenient for routine use, and therefore another object of this paper is to ascertain the experience of the profession throughout Australia on this important matter. From various sources I have collected the following extracts, and must apologize if they appear somewhat disconnected.

Believing myself that ether and chloroform are equally valuable, equally safe (under certain conditions) and equally dangerous, it cannot be said that I have selected these extracts in order to praise up the one or cry down the other.

Dr. Lauder Brunton, in his work on Pharmacology and Therapeutics states: "In many cases of so-called death from chloroform during operations, we find it noted as a matter of surprise that death should have occurred as the quantity of chloroform given was so small. The reason that death occurred probably was because the quantity given was so small. Had the patient been completely anæsthetized the risk would have been very much less."

Professor Syme, when asked why they never had a death from chloroform at the Edinburgh Hospital, remarked, "First we used very good chloroform, and secondly, we gave plenty of it." (See *British Medical Journal*, February 15, 1890, quoted by Dr. Lauder Brunton.) It is a well-known fact that the Scotch, who are still faithful to the much-abused chloroform, believe that it kills by paralyzing the respiratory centre, and therefore they say, "watch the respirations and never mind the pulse," or at least they regard the feeling of the pulse as of secondary importance; and in the account of the recent experiments held at Hyderabad it is stated "that however concentrated the chloroform may be it never causes sudden death from stoppage of the heart." Drs. H. C. Wood and H. A. Hare, M.D. (*Medical News*, February 22, 1890) in their experiments on American dogs show that chloroform acts as a powerful depressant poison upon both the respiration and circulation; that sometimes the influence is more felt at the heart, and death results from cardiac arrest; that in other cases the drug paralyzes primarily the respiratory centre, and that in other cases it acts with equal force upon both medulla and heart, and that cardiac arrest is prone to occur when chloroform is given rapidly and in a concentrated form. A fact to be remembered is that though 450 pariah dogs in India have died of respiratory failure, an equal number of American dogs have died of cardiac arrest, while the records of clinical medicine show that death in the human being from chloroform usually takes place either by primary arrest of the heart, or by a simultaneous arrest of the heart and respiration; whilst in etherization the respiration ceases distinctly before the heart's beats. We (Wood and Hare) believe the roll of deaths from chloroform would be much larger if all the deaths were reported. The surgeon who uses ether knows that he will receive no blame if a death occurs from it, and also that he has a rare case to put on record which will give his own name a permanent place in anæsthetic literature, and therefore he hastens to publish his unfortunate result. Whereas the surgeon who uses chloroform knows that if death occurs from it a large propor-

tion of the profession will condemn him either in public or secret for using this drug. Moreover, deaths from chloroform are only too common, and the surgeon has nothing to gain and much to lose by publication of a chloroform death, and if possessed of the average human nature holds his peace. Referring to the report of the recent Hyderabad commission, the editorial of *The Lancet*, January 18, 1890, states: "The practical outcome of the research would appear to be that deaths from chloroform are not inevitable; they are therefore preventible, and by due care in its administration they may with certainty be avoided." We (Wood and Hare) desire most emphatically to protest against any such language being considered as justified by the work of the India commission. If with due care in giving chloroform accidents may with certainty be avoided, they are, when they do occur, the result of ignorance or carelessness, and the coroner's jury in a given case could scarcely, under the ruling of *The Lancet*, fail to bring an accusation of manslaughter against the surgeon. At least 500 surgeons have had fatal accidents during chloroform anaesthesia, and amongst them we note these names:—Professors Billroth, Dumreicher, Jaeger, Vienna; Sir J. Simpson, Sir G. B. McLeod, Mr. Foy, Great Britain; Drs. Hunter McGuire, J. H. Wellford, Chancellor, Virginia; Drs. W. A. Hammond and A. J. Parsons, Professor W. W. Dawson, &c., U.S.

Does the *Lancet* mean to charge that these accidents could have been avoided; that these men have been practically guilty of taking life through carelessness? (See *Provincial Medical Record*, April 1, 1890). It will thus be seen that as regards experiments, one cannot argue from the pariah dog of India to the American dog, or from dog to man.

In the researches on anaesthetics made by the Glasgow Committee, appointed by the British Medical Association (see *British Medical Journal*, December 18, 1880), the conclusion arrived at was that chloroform and ether both paralyze the respiratory centre before the heart, but that chloroform was the most potent; that deaths from chloroform were due to asphyxia, and where they occurred were due to imperfect observation of the respirations. Mr. Bailey maintains (*British Medical Journal*, December 18, 1880) the death rate is enormously less in England from ether than chloroform.

M. Kapellier (*Progrès Medical*) quotes English statistics 1870-1885, to show that there were 184 cases of death from chloroform and 28 from ether, but adds, "chloroform was used seven times as often as ether."

M. Kroulein (*Progrès Medical*) states he never

employed ether, having every reason to be satisfied with chloroform—in *thirteen thousand* cases of anaesthesia with the latter drug he had never had an accident.

Henry Davis, Teacher of Administration of Anaesthetics, St. Mary's Hospital, London, states: "The bulk of accidents occur to the inexperienced; if ether is used as the routine anaesthetic, and chloroform reserved for those cases in which experience shows it to be most suitable, selected, and administered by persons of experience, we shall find the mortality due to chloroform inhalations suffer a gratifying diminution."

Dr. J. Haward ("Heath's Dictionary of Practical Surgery," article Anaesthetics) states: "During the last ten years ether in England has to a great extent taken the place of chloroform, on account of the general belief entertained of its greater safety; and chloroform in careful hands, and with due precautions, may be given with very little danger."

Böhm ("Ziemmsen's Encyclopædia")—"In a large number of cases deaths from chloroform can be referred to the paralyzing effects of this agent on the heart, but it is no less true that the fatal end is sometimes brought about by paralysis of the respiratory centre. The largest number of deaths have occurred in trifling operations—extraction of teeth—ingrowing nails, etc."

"The enormous clinical experience with ether in America is that ether kills seldom because it is so safe." (Edwin Curtis, "Ziemmsen's Encyclopædia.")

"Ether is the safest known agent for the production of prolonged narcosis." (Dudley Buxton, Administrator of Anaesthetics, University College Hospital, London.)

Provided due care is observed, I think chloroform may be given to all persons, irrespective of their condition, having myself given it without any alarming symptoms in serious heart disease, in every stage of phthisis, Bright's disease—cancer—chronic bronchitis—to patients almost dead of exhaustion from loss of blood—to children of a few weeks, and to persons close on 100. (Ringer, "Handbook of Therapeutics").

"Of these agents—ether and chloroform—the first, ether, is still preferred in the country, where its utility was originally made known; the last, chloroform, is more highly valued in England and in Europe, but the palm of safety must always remain with ether—the simplest, surest, safest of all the potent anaesthetic agents that are known amongst men." (Henry M. Lyman, "Artificial Anaesthesia and Anaesthetics," Rush Medical College, Chicago, 1882.)

"Chloroform should be banished from practice as an anæsthetic agent except in cases in which an extraordinary resistance to the action of ether shows itself." (Schiff, quoted by Dudley Buxton, *Lancet*, vol. 1, 1885, page 588.)

"All anæsthetics are dangerous, but ether is the safest and chloroform the most dangerous." (L. H. Ormsby, *British Medical Journal*, March 7, 1885.)

Meeting of British Medical Association at Cardiff. (See *British Medical Journal*, September 19, 1885.) Discussion on anæsthetics opened by Dr. Dudley Buxton.

"That chloroform is much maligned, I believe, but I venture to think the dread of it is wholesome. As a practical anæsthetist myself, I should not hesitate in many conditions to administer chloroform rather than ether." (Dudley Buxton.)

Professor Fraser did not believe in the difference alleged to exist in the relative mortality of ether and chloroform. Nothing he had ever heard would lead him to believe that ether was distinctly preferable to chloroform.

John Chiene, F.R.C.S., F.R.S.E.:—"During 20 years only saw one death from chloroform. He gave ether a trial for a year, and had one death. Deaths from chloroform are often due to improper or imperfect administration. The surgeon's afraid to give enough. He is in dread of a coroner's inquest. Very rarely are the fatal cases really deaths from chloroform. They are deaths occurring during the administration of chloroform."

Sir J. Lister ("Holmes's System of Surgery"):—"Chloroform has the grand advantage that it may be used alike for the infant and the aged, and those afflicted with pulmonary, cardiac, or renal disease. Wherever an anæsthetic is demanded chloroform is applicable.

"The danger of chloroform may be compared not inaptly to that of railway travelling. In both cases the risk incurred by any individual is so small that it does not enter strongly into our calculation; and just as railway accidents are generally occasioned by mismanagement, so death from chloroform is almost invariably due to faulty administration."

"That chloroform is the most suitable anæsthetic in cases in which cardiac troubles exist is the opinion of many distinguished surgeons." (Foy, "Anæsthetics, Ancient and Modern," 1889.)

Surgeon-major Lawrie, Hyderabad, in the experiments conducted for the Nizam (see *British Medical Journal*, Feb. 23, 1889):—"I have given chloroform as often or oftener than any other man living, and have never had a fatal case, and I can state positively that in the 40,000 or

50,000 administrations I have superintended I have never seen the heart injuriously or dangerously affected by it. I take no credit to myself in this matter. I have simply carried out in India the principles Simpson and Syme practised and taught in Edinburgh."

In selecting an anæsthetic the surgeon must be guided by the case; there is no general anæsthetic. I believe that chloroform is the most generally useful, but there are cases in which, although the anæsthesia was produced by chloroform, it might with advantage be kept up by the use of ether, or the A.C.E. mixture.

Foy, "Anæsthetics, Ancient and Modern," 1890, page 120:—"It is the want of proper training that has brought about a prejudice against chloroform."

Dr. Julian J. Chisholm (Baltimore), in his work, "Chloroform the best of Anæsthetics," says:—"I look upon chloroform as the strong bridge which will conduct patients suffering from serious heart disease safely over serious operations."

Dr. Reeves ("Reference Handbook of the Medical Sciences," vol. 1, V.S.), writes:—"No statistics exist upon which can be based a statement of the ratio of deaths from ether, or as to the relative safety of ether and chloroform."

Dr. Kidd (London) had seen chloroform given in 10,000 cases without a death; and Dr. Bardeleben (of Berlin) had participated in its administration to over thirty thousand patients before meeting with a death. The French surgeons in the Crimea reported 30,000 cases of chloroform anæsthesia and not one fatal issue. In the English army there was one death in 12,000 cases.

Richardson had 15,000 cases and one death; Billroth (Vienna) 12,000 cases and one death; Clover (London) 3000 and no deaths.

Dr. Hunter McGuire, of the Stonewall-Jackson Corps, had 28,000 cases of chloroform anæsthesia and no deaths; and Dr. Chisholm (Confederate service) collected an array of over 300,000 cases of chloroforming, with 48 deaths, or 1 in 7000.

At St. Bartholomew's Hospital, London, chloroform was given in 1885 to 1331 cases, no deaths; in 1886 to 1425 cases, one death; in 1887 to 1702 cases, one death.

Ker states that during the American war there were three deaths from chloroform in 80,000 administrations.

Dr. Lawrence Turnbull ("Artificial Anæsthesia," 1890), holds that ether is the safest anæsthetic for routine use. (See page 336.)

Dr. Donald MacLean (Detroit) was strongly in favour of chloroform. He did not believe the dangers from its use greater than those of ether.

Turnbull, page 377 :—"Chloroform is the most potent and agreeable anæsthetic, but the most dangerous, and is the one in which death may occur at any and every stage by inhalation; it kills so suddenly that neither skill nor care can always guard against a fatal result."

Turnbull, page 377 :—"It should not be administered when other anæsthetics are available, except under special circumstances."

Dr. Marion Sims uses ether in preference, and never feels the least danger from it under any circumstances.

Sir George H. B. MacLeod, M.D., at the meeting of the British Medical Association at Glasgow, 1888, states: "I myself after fairly trying most of the agents in use now exclusively employ chloroform, and having for years kept an accurate record of its administration and given it freely and without stint in all cases of surgical proceedings, never refusing its benefits to a single patient, no matter what his condition or the operation to be performed; I have never had an accident, except once, when an epileptic took a fit whilst being put under its influence, and died with a full and fixed chest. For speed and energy, for ease of application and agreeableness, for rapid recovery with little subsequent trouble, and for safety when properly administered chloroform is, in my opinion, unrivalled." (Turnbull, page 408.)

"On the choice of General Anæsthetics in Surgery and Obstetrics by Dr. Hunter McGuire, Richmond, 1887": "Throughout the civilized world chloroform is much more generally used than ether, in fact it is used 20 times as often as ether. Up to the present time 400 to 500 deaths from chloroform and 100 from ether have been reported, but he was unable to say what the ratio of deaths by either agent is to the total number of administrations."

Chloroform has been given to hundreds of thousands of women in labour with but one fatal case (so far as he has learned), and that a doubtful one. In the last text book of surgery, issued in 1887, is the following: "Ether is so much safer than chloroform that the latter is fast disappearing in practice. The estimated death rate after ether is 1 in 20,000; in chloroform 1 in 3,000." To which Dr. McGuire replies: "Such statements are the outcome of prejudiced brains, and are absolutely unwarranted by any facts or figures known to the profession."

Dr. F. W. Silk, Anæsthetist to the Great Northern Hospital, London, says: "Ether is infinitely safer, though chloroform in certain cases is invaluable. Chloroform should not be employed for general use."

From the *Medical Times*, Philadelphia, May 14, 1887, Dr. H. Knapp states: "From 1860 to 1874 I used chloroform in over 3,000 cases without a fatal result, but with many alarming symptoms. I now use ether, and consider it safer than chloroform."

Dr. A. G. Gerster states that both chloroform and ether are dangerous. Chloroform is the more powerful agent, and its administration requires much greater caution. But this is not sufficient ground for its unqualified condemnation. Consciousness being restored there is no secondary danger from chloroform; but the dangers from ether do not cease the moment the patient comes from under its influence. There was too much one-sidedness in favour of ether among physicians of the eastern cities.

There was but one contra-indication to the use of chloroform, viz., a weak heart from any cause whatever, but valvular disease did not necessarily mean a weak heart.

Dr. L. A. Sayre said: "He was so thoroughly convinced of the correctness of his own views regarding the relative value of ether and chloroform that he had continued the use of chloroform notwithstanding the general opposition towards it."

Dr. Gerster states: "Statistics, as they had been collected, were worth nothing in deciding whether ether or chloroform was the safer anæsthetic. He knew of five deaths from ether in one hospital which had never been reported." *Medical Times*, May 14, 1887.)

I much regret that limited time prevents me from gathering further information, and can only hope that what has been written will be of some value.

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LETTERS TO THE EDITOR.

THE DISPOSAL OF THE EXPECTORATION OF CONSUMPTIVES.

(To the Editor of the A. M. Gazette.)

SIR,—During the last Intercolonial Medical Congress we had some lengthy and animated discussions on typhoid fever and hydatid disease. Everyone that attended those sittings must have derived much benefit from the experience brought forward.

In typhoid fever and hydatid diseases our main attention must be directed to the prevention of them. If the appropriate measures are vigorously enforced we will be able, if not to stamp them out altogether, at least to minimize the victims. To the same class of diseases belongs consumption, which, as the death statistics of all the civilized countries show, ranks foremost amongst the causes of death. Tuberculosis is one of the few diseases the nature of which is well understood, we are often able to recognize the disease in its infancy, we can follow its course, but, alas! our cures are few and far between. If this be the case it is our duty to check the spread of this formidable disease.

When I first arrived in the colonies I settled in the north of Victoria. I came with the idea that Australia was the "Eldorado" free from consumptive people, except the imported ones. But I found myself quickly undeceived. I had hardly commenced practice when I was called to see a consumptive patient, a native of the colony. He was sent up-country by his medical adviser to get rid of him before he died, to put it plainly. But what struck me most was the utter absence of any instruction to the patient as to the disposal of his sputum. He expectorated on the floor, in the fowl yard, in his handkerchief, everywhere he should not, fully unconscious of his spreading death broadcast about him. Soon after I had to attend a family, the mother and two daughters of which died within a very short time of each other. Another daughter and sister of the mother had died some time previously. The same habits of disposing of the sputum obtained here.

In both instances I inquired into the family history and found that consumption was unknown on either side of the parents' antecedents, so also was scrofula and syphilis.

The same observation was made many times after my attention was first drawn to this subject.

As the disposition to consumption was not inherited, some other factors must be at work in the same direction, viz.: preparing the lung tissue for the development of the tubercular bacillus. On the other hand, consumption is a contagious disease, its spread is due to contagion, therefore our aim must be to prevent the latter. How widespread the poison is was shown by Cornet, who found the active germ in the dust on the walls of clinical wards, prisoners' rooms, etc., formerly occupied by phthisical patients, whereas Hoffman found the virulent bacillus in the intestines of the common house fly and its deposits. In milk the bacillus is found, as well as in the meat of beasts killed and retailed for consumption. Positive results with injection of tuberculosis meat or meat juice into rabbits or guinea pigs were reported by Johnes, Gerlach, Veyssiére et Humbert, Dreschfeld, and others. Milk is proved by experiments to be a suitable pabulum for communication of phthisis.

Impressed with these facts I myself made experiments with positive results, which I am sorry to say have now come to a standstill owing to the delay in granting permission to keep rabbits.

In the face of these facts our line of action is clearly laid out, viz.: first, to ascertain the causes which are at work in predisposing the lung tissue for the disease and then eliminate them as far as possible; secondly, to use our utmost influence to introduce such measures as will prevent the contagion. Therefore, I would ask the Committee of the next Congress to set apart a day for the discussion of prevention of consumption and questions allied to it. I dare say the same suggestion will have been made by many medical men more able to speak on the matter than myself, therefore I must apologize for intruding on the Committee, but as the subject has been on my mind for some time I could not help bringing it before the profession, prompted by the paragraph in the last issue of this paper reminding the reader of the coming Congress.

The question is a very important one and as it involves some legislative measures it should be well ventilated before it is brought before the Congress for final discussion.—Yours, &c.,

J. B. ROSS, M.D.

Warrnambool (Victoria), April, 1890.

DR. MARTEN'S CASE OF EXTRA-UTERINE FETATION CURED BY THE FARADIC CURRENT.

(To the Editor of the A. M. Gazette)

SIR,—Dr. Elsner begins his letter on the above case by criticising the term "cured," but as the patient improved from the day the treatment was applied, and left for England with a "slight thickening in the left broad ligament," just three and a half months afterwards, I think the term is justified, especially as Dr. Elsner himself quotes a case in the Intercolonial Medical Congress, Session 1887, where he "completely cured" a case of "Pyloric Stenosis due to alcoholic thickening," i.e., completely cured away cicatricial connective tissue by simply washing out the stomach. After this he must allow that we might have destroyed the vitality of a fifteen weeks' foetus by the strong Faradic current. Dr. Elsner differs with Professor Lawson Tait as to whether the foetus may or may not be absorbed. The former states that "the bones remain in their place if not extracted or expelled in some manner until the death of the parent;" the latter in his work on "Diseases of Women and Abdominal Surgery," on page 470 states:—"The ovum dies and everything is absorbed, I am quite sure that I have watched several cases." I would sooner trust to Professor Tait's observations than Dr. Elsner's statements.

I cannot admit, as stated by Dr. Elsner, that "all the cardinal points necessary to establish the existence of extra-uterine foetation" according to Lawson Tait and Reeves were absent in my case, for not only are all those present upon which Tait lays stress, but in addition the signs of a probable pregnancy on which other authorities are inclined to place reliance are there to confirm, or at least support, the diagnosis. I think if Dr. Elsner would read the report of the case carefully through and compare it with Tait's work he would hardly have allowed himself to make such statements.

Another point which receives unfavourable criticism from Dr. Elsner in my case, is that due weight was not given to the absence of an antecedent sterility. This is by no means to be necessarily insisted upon, as even Professor Tait, in the first and third cases quoted by him in the abovementioned work as typical examples of extra-uterine foetation, allows the patients did not suffer in this way.

With regard to the bruit, Dr. Elsner states that "a bruit may be heard if a binaural stethoscope be introduced into any cavity of the body." This is incorrect, as we distinctly noted that the bruit was audible only on the side of the vagina where the swelling was, and that in three weeks' time when the swelling was much smaller, no bruit was audible at all within the vagina; the bruit we heard had all the characters of a hæmic bruit, and was no doubt produced in the enlarged vessels connected with the growing placenta; we know a bruit is present in fibroids, but there was no fibroid present to produce it.

Dr. Elsner next refers to the collapse on November 15, and believes this to have been due to internal hæmorrhage, but makes no distinction between an intra and extra peritoneal hæmorrhage, which, if he refers to Tait, will be found to be of the greatest importance both as regards prognosis and treatment. I stated in my paper that the pain was probably due to rupture of the cyst wall, thus giving rise to an extra-peritoneal hæmatocele, and from the successive recurrences of the attacks of pain to conjecture that the fœtus was growing to within four days of our operation.

With regard to Huguier's case, quoted by Dr. Elsner from Playfair's work, the sound appears not to have been passed, by which action, if it had been taken, Huguier and the six or seven other obstetricians would have almost certainly been prevented from coming to the erroneous conclusion that the case was one of extra-uterine foetation when the fœtus was in the uterus; and Playfair himself admits that in these cases positive diagnosis must always be very difficult, and allows that in certain cases "the suspicion of tubal pregnancy may be sufficiently strong to justify us in taking such action as may possibly spare the patient the necessarily fatal consequences of rupture."

This we did, and found the uterus only slightly over 2½ inches long, dispelling entirely the idea that there could have been an intra-uterine fœtus of 15 weeks.

With regard to Dr. Elsner's suggestion that it would have been better had four medical men been present at the consultation, I could easily have remedied this had I known that there was a gentleman in Melbourne and another in Sydney who were able to make a diagnosis without seeing the patient.

Dr. Worrall cites in his letter a case which, in my opinion, demanded laparotomy much more certainly than mine did, and yet he left the patient suffering from profound collapse, anæmia and vomiting, with also "a damaged and useless tube, likely to be a cause of trouble and suffering for many years." He also flipperily disposes of electricity, which, however, is believed in by some of the foremost gynaecologists in America, and I would refer him to the April number of the *International Journal of the Medical Sciences* for statistics. In fact, on reading his letter one is disposed to think that his necessarily very limited experience of such cases hardly gives him the right to talk so dogmatically.

I may say that I am an adherent of Lawson Tait's teaching with regard to the value of laparotomy in intra-peritoneal rupture of tubal pregnancy, but both Dr. Gardner and myself were distinctly of an opinion that this was a case either for leaving to nature or one in which electricity might be tried.

On this day on which I am writing my colleague, Dr. Gardner, diagnosed a case of intra-peritoneal rupture of tubal pregnancy, and performed laparotomy. The cyst could easily be made out on opening the abdomen, and the fingers passed into the rent in the cyst-wall. Adhesions were separated and the cyst removed, and a ligature applied close to the uterus; a

large, bleeding vessel was tied in the torn, broad ligament, and handfuls of clot were washed out of the abdominal cavity. I have no doubt he will publish this case in full to shew that we are both capable in South Australia of making the diagnosis and applying in each case the appropriate treatment required.

I am, Sir,

Yours sincerely,

R. HUMPHREY MARTEN.

66 Rundle-st., Adelaide,

May 31, 1890.

ON HOMŒOPATHY.

(To the Editor of the A. M. Gazette.)

SIR,—Referring to your stricture on my letter in your May number, if by "successful" you mean money-making, then you know that there are allopathic quacks as well as homœopathic quacks in this city who have amassed fortunes, thus showing that these men possessed a certain *business savoir faire* but not that they possessed any medical knowledge, either allopathic or homœopathic. The day has gone by for associating homœopathy with quackery, as the sequel will show. We have not one registered medical practitioner possessing a legal homœopathic qualification that I know of, though we have several registered allopaths practising more or less homœopathically according to their ability; indeed nearly the whole profession is doing so in a rough sort of way.

Let us compare the words of Hahnemann, Brunton, and Ringer.

Hahnemann's "Materia Medica Pura," preface, says: "Every single medicinal substance is capable of curing a case of disease, the symptoms of which shall be exactly analogous to those which the medicinal substance is capable of producing upon a healthy organism."

In this definition of homœopathy Hahnemann says nothing about dose or quantity.

Hahnemann's "Organon," introduction, page 106, says (Dudgeon's translation): "There have ever been occasionally physicians who vaguely surmised that medicines cure analogous morbid states by the power they possess of producing analogous morbid symptoms." Amongst them Hippocrates.

"I do not bring forward the following passages from authors who had a presentiment of homœopathy as proof in support of this doctrine, which is firmly established upon its own merits, but in order to avoid the imputation of having suppressed these foreshadowings with the view of securing for myself the merit of the priority of the idea."

Brunton, in the preface of the third edition of his "Text Book of Pharmacology, Materia Medica and Therapeutics," says: "The mere fact that a drug in small doses will cure a disease exhibiting symptoms similar to those produced by a large dose of the drug does not constitute it a homœopathic medicine, for this rule was known to Hippocrates, and the rule *similia similibus curantur* was recognized by him as true in some instances. But Hippocrates was not a homœopath, and he recognized the fact that while this rule was sometimes true, it was not invariably so."

Again he says: "And the only difference between them (i.e. homœopaths who have discarded the infinitesimal dose) and rational practitioners (i.e. allopaths of Brunton's type) lies in the fact that the latter regard the rule as only of partial application."

Brunton does not say how partial this application is

to be in order to constitute its applier a "rational practitioner."

Such then are the dimensions to which the opposition to homœopathy has dwindled in the mind of a recognized allopathic teacher.

Let us compare the following extracts from Brunton with Hahnemann's definition of homœopathy. Second edition, page 289, says: "Cardiac Tonics.—All these drugs, as already mentioned, stimulate the cardiac muscle and render its contractions slower and stronger. Although in large doses they tend themselves to *produce* irregular and peristaltic contraction of the heart, yet in moderate doses they tend to *remove* irregularity already present."

Page 217 says: "We are able to observe a similar difference between the effects of small and large doses in the case of iodide of potassium; a small dose of a grain and a half taken by a healthy man three times a day will almost certainly cause the nose to run freely, while if the dose be increased to ten, twenty, or thirty grains the excessive secretion will almost certainly be arrested."

Page 337 says: "It is possible that the beneficial action of Bael fruit in dysentery may depend upon some similar property, as this substance has the peculiarity of acting as a laxative in health, while it lessens the evacuations in dysentery."

"Ringer's Handbook of Therapeutics," 11th edition, page 386, says: "To Dr. Brunton belongs the distinction of first using this remedy, Nitrite of amyl, and the rare merit of correctly inferring its therapeutic effect from its physiological action."

Ringer then enunciates the physiological effects, giving the physiological dose, and states that these same symptoms or effects occurring as disease may be removed by a much smaller quantity (*viz.*, $\frac{1}{10}$ minim) of the same remedy.

By what other rule than that of *similia similibus curantur* could Brunton infer the therapeutic effect from its physiological action?

Of what therapeutic use is it to an allopath to know that nitrite of amyl causes flushings of face, throbbings of carotids, sinking at the epigastrium, cold hands and feet, &c.?

The only condition that homœopathy postulates about the size of the dose is that the therapeutic dose shall be smaller than the physiological dose, but how much smaller it does not say.

Brunton conveys this idea in the following statement, page 151, 2nd edition: "When strychnia is given in cases of paralysis until it begins to exhibit its physiological action in slight muscular twitches, these twitches begin sooner and are more marked in the paralysed than the healthy parts."

"Now it is clearly apparent that what Hahnemann defines as homœopathy Brunton declares is *not* homœopathy, and for the reason only that this rule *similia similibus curantur* was known to Hippocrates, and was recognized by him as *true in some instances*.

It is this "*mere fact*" which does constitute a drug a homœopathic medicine, and when Hippocrates resorted to this rule to direct him to a remedy he so far practised homœopathically.

That in other cases he was guided in his choice of medicines by the rule of contraries only proves that he was not so much of a homœopathist as he might have been had the knowledge of the physiological action of drugs been greater in his time than it was.

Brunton states in preface to his 3rd edition: "After I had begun to do this, *i.e.*, prepare a Therapeutic Index, I found that a similar idea had occurred to Dr. S. O. L. Potter, who had already published an "Index

of Comparative Therapeutics," in which he gave a list of remedies taken from the works of Aitken, Bartholow, Niemeyer, Phillips, Pifford, Ringer, Stille, Tanner, Trousseau, H. C. Wood, Waring and some others."

"After finding that Dr. Potter had compared together more works than I expected to do, I used his list in preparing my Index."

"Dr. S. O. L. Potter's work on comparative therapeutics was published in 1880, and Dr. Potter is a graduate of the Homœopathic Medical College of Missouri of 1878, and was a member of the American Institute of Homœopathy, and practised homœopathically at Milwaukee. So that it is to the work of one who had made himself familiar with homœopathic practice that Dr. Brunton is indebted for his Index."—Dr. Dudgeon.

"Dr. Charles D. F. Phillips practised homœopathically for twenty years before the publication of his work, in which 'there are some remedies mentioned without any references.'"—Dr. Dudgeon.

These then are the sources whence Brunton and Ringer learnt the uses of bryonia, pulsatilla, euphrasia, hamamelis, cyanide of mercury, ignatia, achillea, gold, calendula, cocculus, apis, physaloea, thuja, rhus toxicodendron and viola tricolor—remedies not to be found in the British Pharmacopœia—and have also learnt the novel application of old remedies, such as the treatment of abscess with small doses of calc. sulphide; albuminuria with drop doses of cantharides; asthma with arsenic and ipecac.; irritable bladder with cantharides; bronchitis with arsenic; boils with arsenic and sulphides; cholera, colic, gastralgia and gastritis with arsenic; diarrhoea and dysentery with arsenic and corrosive sublimate; cystitis and nephritis with cantharides; laryngitis with iodine; menorrhagia with savin; pneumonia with phosphorus; typhoid fever with arsenic and phosphorus; vomiting with ipecac., tartar emetic and zinc; and many others.

Your readers will get a few further "tips" on this subject from the Homœopathic League Tracts, Nos. 14 and 15.

I am, &c.,

W. G. WATSON, M.A., M.B., L.S.A., M.R.C.S.,
Late House Surgeon and Physician's Assistant Univ.
Coll. Hosp., Lond.

150 Elizabeth-st., Sydney,
May 28, 1890.

THE INSANE POPULATION OF NEW SOUTH WALES IN 1889.

DR. F. NORTON MANNING, Inspector-General of the Insane in New South Wales, has favoured us with his report on the Hospitals for the Insane for the year 1889, which shows that the number of the Insane on 31st December, 1888, was 2,898, and the increase during the year 76, 46 males and 30 females. This increase was exactly the same as during the previous year, but less than the average for the last ten years, which was 96. Of the number on the registers, 2,894 were at the close of the year in Institutions for the Insane and 80 were absent on leave. The estimated population of the Colony at the close of the year was 1,122,200, so that the proportion of insane to population at that time was 1 in 377, or 2·65 per thousand. This proportion is slightly less than that for last year and is considerably below the proportion in England,

which, at the close of 1888 was 1 in 344. During the last twenty years the proportion of insane to population in New South Wales has ranged from 1 in 352 to 1 in 379, and is now within a fraction of what it was at the close of the year 1870, so that, although the number of insane persons has increased by 1,685 during the last twenty years, there has been no increase in proportion to the population of the Colony. The admissions and readmissions during the year number 599, making a total of 3,497 patients under care in 1889. Of these 244 recovered, 12 were relieved, 49 transferred, 9 escaped, and 209 died, a total of 523 discharged and died during the year, leaving 2,974 patients under care in the hospitals on 31st December, 1889.

Of the 3,497 persons under care, 1,899 were single, 1,048 married, 210 widowed, and 310 could not be ascertained. As regards the ages 94 were between 15 and 20 years of age, 513 between 20 and 30 years, 819 between 30 and 40 years, 834 between 40 and 50 years, 626 between 50 and 60 years, 353 between 60 and 70 years, 147 between 70 and 80 years, etc.

The principal causes of insanity in the admissions and readmissions during the year were 63 from intemperance, 35 were ascribed to hereditary influences, 34 to old age, 24 to parturition, 24 to epilepsy, 20 to congenital defect, 18 to sunstroke, 17 to injury, 16 to domestic troubles, etc.

Of those discharged recovered 10 were detained in the hospitals under 1 month, 43 from 1 to 3 months, 72 from 3 to 6 months, 56 from 6 to 12 months, 34 from 1 to 2 years, 22 from 2 to 5 years, 5 from 5 to 10 years, and 2 for over 15 years.

Of the total number under care, 1,085 were natives of New South Wales and 118 of the other colonies, 944 came from Ireland, 859 from England, 177 from Scotland, 81 from Germany, 77 from China, and 21 from France.

The average daily number resident was 2,889; and the death-rate, calculated on the average number resident was 7.23, being somewhat over the average rate for the ten years, 1880 to 1889, which was 6.80.

The total expenditure during the year was £100,302 4s. 5d.; the amount of collections by the Master-in-Lunacy, £11,192 10s., and the annual cost per patient, deducting collections, £29 6s. 3½d.

L. BRUCK, Medical Bookseller, Sydney,

Has added the following recent publications to his magnificent stock of Medical Books for sale:—

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 BEVAN LEWIS, TEXT BOOK OF MENTAL DISEASES, 1889, 28s.
 WINCKEL'S DISEASES OF WOMEN, 2nd ed., 1889, 12s. 6d.
 EUSTACE SMITH, DISEASES IN CHILDREN, 2nd ed., 1889, 22s.
 TAYLOR'S PRACTICE OF MEDICINE, 1890, 15s.
 ALLINGHAM, INTERNAL DERANGEMENTS OF KNEE JOINT, 1889, 6s.

&c., &c., &c.

Postage extra, at the rate of 1s. 6d. to the £ of order.

THE MONTH.

NEW SOUTH WALES.

IN the Legislative Council, on May 15, it was agreed, on the motion of Dr. Garran, that an address be presented to the Governor, praying that his Excellency will be pleased to cause to be laid upon the table of this House copies of the letter sent to the Colonial Secretary in 1887, urging the necessity of legislative action by the Government for the regulation of the practice of medicine and surgery in New South Wales, which was signed by the Lieutenant-Governor, the Chief Justice, his Eminence Cardinal Moran, the late L'imate and other gentlemen, together with any minutes or memoranda on and replies; also, of the letter sent by the president of the New South Wales Branch of the British Medical Association to the Colonial Secretary during the present year, together with any enclosure in, minutes or memoranda on, and replies to it.

IN the Legislative Council on May 22 Dr. Bowker moved for leave to bring in a bill to regulate matters with regard to the practice of medicine and surgery in the colony of New South Wales. The motion was agreed to.

OUT of about 500 practitioners to whom queries were sent by the Board of Health as to their observations in connection with epidemic influenza in the colony 300 have replied. From a cursory glance which has been made through the replies received it appears that the disease has been prevalent throughout the colony, but not to a very great extent.

IT is intended to establish a cottage hospital at Wallsend.

THREE cases of deaths under chloroform have recently occurred at the Prince Alfred Hospital, Sydney, within as many weeks.

THE total number of patients admitted into the Coast Hospital at Little Bay, near Sydney, during last year, was 1813, which, with four from last year, makes a total of 1817 under treatment. Of these 1369 were discharged well, 253 better and 32 unimproved; 53 were transferred to Government asylums for the infirm and destitute, 4 to public hospitals, and 7 to hospitals for the insane, whilst 99 died. Compared with the year 1888 there were 119 more patients admitted, and the proportional number of those discharged as cured had considerably increased. The total number of deaths from typhoid was 342, as against 241 in 1888. The cases were received from nearly every part of the metropolitan and suburban area. In 1889 52 cases of erysipelas were also admitted. The return shows a falling off in the number of cases of measles and scarlet fever and an increase in those of diphtheria and whooping cough. The latter was unusually prevalent in Sydney and suburbs for some months.

AT the Sydney Quarter Sessions on May 29, Dr. John MacLeod, formerly of Ross (Westland), N.Z., and also of Woollahra, near Sydney, was found guilty of bigamy and remanded for sentence to 16th June.

MR. GEORGE SEEJEANT, M.R.C.S. Eng. 1881, L.S.A. Lond. 1882, died at Balranald on the 16th May, at the early age of 33, from consumption. He arrived in Victoria in July 1888, when he commenced practice at Ballarat. He afterwards removed to Echuca, and was appointed Medical Missionary to the Cumeroogunga Aboriginal Mission Station near Moama. Last

year he settled at Balranald, where he held the positions of Medical Officer to the local hospital and Government Medical Officer for the district.

DR. J. R. ANDERSON, of Ryde, has succeeded to the practice of Dr. S. A. Dowe at Granville.

DR. ALEX. BARBER, late of Mudgee, has been appointed Medical Officer of the Hillgrove Hospital and of the Hillgrove United Medical Association.

DR. W. P. BASSETT has been elected an Honorary Medical Officer of the Bathurst Hospital.

DR. CRAIG DIXON, having resigned his office of Honorary Surgeon to the Sydney Hospital, has been unanimously appointed Honorary Consulting Surgeon of the institution in recognition of his long services.

DR. S. A. DOWE, late of Granville, has left for Broken Hill with the intention of commencing practice in that district.

DRS. EDMUNDS and KIRKLAND have been appointed Honorary Medical Officers of the Bathurst Hospital, and Dr. W. F. Bassett still retains the position of Honorary Consulting Medical Officer to the institution.

At a recent meeting of the Carcoar Hospital Committee a resolution was passed, expressing admiration at Dr. Kelty's skill, and also to present him with an illuminated address testifying to his ability and their regret at his departure.

DR. A. K. MORSON has removed from West Maitland to North Shore, a suburb of Sydney.

NEW ZEALAND.

At the Wellington Hospital 44 cases of typhoid fever were treated during the year, with five deaths, or a death-rate of 11 per cent.

THE death is announced of Mr. Maurice Alfred Chilton, L. et L. Mid. R.C.S. et R.C.P. Edin. 1878, formerly Medical Officer of the Waimate, Christchurch and Wellington Hospitals, who died at Manaia (Taranaki) on April 18.

DR. ALFRED GEORGE BUCKLAND, M.D. 1877, M.B. et Ch.M. 1875, Aberd.; M.R.C.S. Eng. 1875, L.S.A. Lond. 1874, died at Nukualofa, Tonga Islands, on the 30th March at the age of 40. The deceased gentleman was formerly Demonstrator of Anatomy at the London Hospital Medical College, also House Surgeon and Clinical Assistant at the London Hospital. About eight years ago he settled at Tonga, where he practised ever since.

DR. W. W. CHRISTIE has removed from Woodville (Hawke's Bay) to New Plymouth, the capital of the province of Taranaki.

DR. F. C. S. FORBES, late of the Auckland Hospital, has commenced practice at Tauranga.

DR. H. MCC. INGLIS has removed to Waipara, 41 miles from Christchurch.

DR. F. W. INNES, of Napier, has been appointed a member of the Napier Medical Board, as provided for by "The Military Pensions Act, 1866," *vice* Alfred Chevalier Preston, M.R.C.S.E., who has left the district.

DR. A. C. MILNE has removed from Masterton to Woodville, 100 miles S.W. of Napier.

DR. G. A. MORRIS, late of Maitland, is now practising at Cromwell, 165 miles N.W. of Dunedin.

QUEENSLAND.

THERE were no less than 78 applicants for the position of Resident Surgeon for the Mount Morgan Hospital. The committee appointed Dr. R. R. Hunter, formerly of Coonamble (N.S.W.), to the much-coveted position. Dr. Hunter has been practising at Mount Morgan for some time, and we learn that the action of the committee in electing him has met with the approval of all the principal residents of the township.

WE are pleased to learn that Dr. Lockhart Gibson, of Brisbane, has sufficiently recovered from his recent severe illness to resume practice. Dr. Gibson will confine his work to eye, ear and throat cases and consulting practice.

DR. H. C. PURCELL, of Brisbane, having served twelve years as Surgeon of the Queensland Defence Force with relative rank of Captain, has been promoted to be Surgeon-Major.

SOUTH AUSTRALIA.

STEPS are being taken towards the erection of a suitable building for a hospital at Port Pirie. A circular appeal has been issued, which states that the Government have placed £1,500 on the Estimates for the purpose; but the sum is, however, altogether insufficient to cover the cost of building and furnishing, which will not be less than £2,500. In the past cases have had to be sent on to Jamestown, Burra, or Adelaide Hospitals, at great risk, pain and inconvenience to the sufferer and expense to the country.

DR. R. K. ARCHER is about to remove from Moonta to Glenelg. He will be succeeded by his brother, Dr. E. L. Archer, who practised at Moonta for a number of years, and then left for London, where he has since practised.

DR. F. E. RENNER has removed from Koolunga to Petersburg.

TASMANIA.

THE death is announced of Mr. Charles Henry Elliott, M.R.C.S. Eng. 1858, L.S.A. Lond. 1859, who died at Franklin on May 1, aged 55 years. The deceased gentleman, after practising at Fremantle (W.A.) for some years, removed to Adelaide in 1883, and to Tasmania in 1886; he practised at Evandale, then at Launceston, and finally removed to Franklin about twelve months ago.

MR. THOMAS WILSON, M.R.C.S. Eng. 1849, formerly Assistant Surgeon in the Royal Navy, but since September 1860 a resident of the Emu Bay district, died at Wynyard on the 29th April, at the age of 63 years; the deceased gentleman held the position of Government Medical and Health Officer for the district.

DR. J. C. HOOD, late of Victoria, has settled at Sorell, near the coast, 16 miles east of Hobart.

DR. C. G. JACKSON, a new arrival, has commenced practice at Campbell Town, 91 miles north of Hobart.

DR. H. M. MADDEN, formerly of Franklin and late of Moss Vale (N. S. W.), has resumed practice at Franklin, 28 miles south-west of Hobart.

VICTORIA.

A LARGELY attended meeting of the Medical Society was held last month under the presidency of Mr. T. M. Girdlestone, at which the consideration of the question of hospital abuse was continued. The following resolutions were discussed, and finally carried unanimously:

"This society is of opinion that—1. Great imposition on the part of well-to-do people is practised at the public hospitals, which is contrary to the principle on which these institutions were founded, and on which they should be conducted. 2. All hospitals receiving Government aid annually should be devoted solely to the treatment of the destitute and poor. 3. Paying patients should not be admitted into hospitals receiving Government aid granted for the benefit of the destitute and poor. 4. A wage limit should be fixed for all hospital patients (i.e., all those earning more than a certain amount should be excluded). The society suggests a wage limit of £2 a week for single men, £3 a week for married men, and £6 a week for families in which there are several wage-earners. That the circumstances of each applicant for admission should be investigated by an officer specially appointed for the purpose, who should use wide discretionary power in special cases." It was decided to appoint Drs. Balls-Headley, Barrett, Girdlestone, Jackson, Neild, and J. P. Ryan as a committee to represent the opinions of the society to the Charitable Commission.

DURING the week ending May 24, 106 cases of typhoid fever, of which 10 were attended with fatal consequences, were reported to the Board of Public Health. 83 cases of diphtheria, of which 20 had proved fatal, were also reported.

MR. JOHN BLEECK, M.R.C.S. Eng. 1846, L.S.A. Lond. 1817, died suddenly on the 26th May at his residence at Heidelberg, at the age of 66 years.

MR. THOMAS KERSLAKE ROBINSON, L. et L. Mid. R.C.P. et R.C.S. Ed. 1885, L.F.P.S. Glas. 1885, son of Dr. Charles Robinson, of Heathcote, died at Omeo on 31st May, at the early age of 34 years.

DR. J. V. C. DENNING, late of Macarthur, has gone home.

DR. W. GILLESPIE, formerly of Corryong, has settled at Swan Hill, he having been appointed medical officer of the local hospital.

DR. F. M. HARRICKS has returned from his trip to England and resumed practice at Alma-road, St. Kilda.

DR. G. C. JACKSON, formerly of Katoomba (N.S.W.), has settled at Macarthur, 244 miles W. of Melbourne.

DR. A. A. JOHNSTON, late of Moruya and formerly of Parkes (N.S.W.), has settled at Sunbury, 24 miles N.W. of Melbourne.

OWING to the intended early departure for Europe of Dr. E. M. James, he has been obliged to sever his connection with the Melbourne Hospital as hon. surgeon, which has extended over a period of 37 years.

DR. G. J. SCANTLEBURY has removed from Linton to Cheltenham, 12 miles south of Melbourne.

MEDICAL APPOINTMENTS.

Donaldson, James Blair, L.R.C.P. et R.C.S. Ed., L.F.P.S. Glas., to be Public Vaccinator for Linton, Vic., vice Dr. G. J. Scantlebury, resigned; also Health Officer for shire of Ripon, Vic.

Ewbank, William Withers, M.R.C.S.E., to be a Public Vaccinator in South Australia.

Flanagan, Patrick James, M.B. Melb., to be Health Officer for Flemington and Kensington, Vic.

Franklin, Thomas Evans, L.R.C.P. et R.C.S. Ed., to be Assistant Medical Officer at the Coast Hospital, Little Bay, near Sydney.

Gibson, John Lockhart, M.D. et Ch. M. Ed., M.R.C.S.E., to be Hon. Ophthalmic Surgeon to the Dunwich Benevolent Asylum, Qu. Griffiths, Christopher Arthur, M.R.C.S.E., to be Health Officer for shire of Caulfield, Vic.

Hearn, William Edward Le Fanu, M.B. Melb., L.K.Q.C.P. Irel., to be Public Vaccinator at Kensington, Vic.

Hialop, Walter, M.B. Univ. N.Z., to be Public Vaccinator for the district of Palmerston South, N.Z.

Inglis, Herbert McClelland, M.B. et Ch. M. Ed., to be Public Vaccinator for the district of Waipara, N.Z.

Johnston, Arthur Alma, M.K.Q.C.P. Irel., L.R.C.S. Ed., to be Public Vaccinator at Sunbury, Vic., vice Dr. Thos. Hodgson, resigned.

Kane, Francis William, L.R.C.P. et R.C.S. Ed., L.F.P.S. Glas., to be Govt. Medical Officer and Vaccinator for the district of Cobarr, N. S. W.

Leecher, Henry Adolf, M.B. et Ch. M. Ed., to be a Public Vaccinator in South Australia.

Milne, Alexander Cumming, L.R.C.P. et R.C.S. Ed., L.F.P.S. Glas., to be Public Vaccinator for the districts of Woodville and Danevirke, N. Z.

Morris, George Alexander, M.B. et Ch. M. Glas., to be a Public Vaccinator for the district of Cromwell, N. Z.

Peebles, Frank Montgomerie, M.B. Melb., appointed Resident Medical Officer at the Women's Hospital, Melbourne, vice Dr. Martell, promoted.

Rabl, Heinrich, M.D., to be Public Vaccinator for Murtos, Vic., also Health Officer for Dummunkle shire, W. R.

Sandford, Arthur William, L.R.C.P. et R.C.S. Ed., L.F.P.S. Glas., to be Public Vaccinator for North Carlton, Vic., vice Dr. M. Mailer, resigned.

Scott, John Melby, M.B. Melb., to be Junior Resident Medical Officer at the Hospital for the Insane, Parramatta, N. S. W.

Smith, Otto Wien, M.B. et Ch. M. Ed., to be a Public Vaccinator in South Australia.

Taylor, George Henry, L.R.C.P. et R.C.S. Ed., to be Visiting Surgeon and Dispenser to the Trial Bay Prison, N. S. W.

Theed, Stanley Wipon, L.R.C.P. Ed., M.R.C.S.E., to be Public Vaccinator for Morningside, Vic., vice Dr. F. L. Hooper, resigned.

Webster, George Alexander, M.B. Camb., M.R.C.S.E., to be Public Vaccinator at Caulfield, Vic.

BIRTHS, MARRIAGES, AND DEATHS.

*•• The charge for inserting announcements of Births, Marriages, and Deaths is 2s. 6d., which should be forwarded in stamps with the announcement.

BIRTHS.

ADAM.—On the 10th May, at Beaufort, Vic., the wife of Basil J. Adam, M.B., of a daughter.

BARR.—On the 20th May, at Glenferrie, near Melbourne, the widow of the late Dr. T. J. Barr, of a son.

BUTTNER.—On the 14th May, at East Melbourne, the wife of Dr. Alex. Buttner, of a son.

COX.—On the 7th May, at Balaslava (Melbourne), the wife of Dr. Jas. Cox, of a daughter.

CUMMINGS.—June 2, at Annandale, Sydney, the wife of Harold L. Cummings, M.R.C.S., L.R.C.P. Lond., of a son.

JENKINS.—June 3, at 213 Macquarie-street, Sydney, the wife of Edward J. Jenkins, M.D., of a son.

LONG.—May 9, at Wagga Wagga, N. S. W., the wife of Dr. St. Clair Long, of a daughter.

NIESCHE.—On the 18th May, at Adelaide, the wife of F. W. Niesche, M.D., of a daughter.

TRAILL.—June 2, at Burwood, Sydney, the wife of Mark W. Traill, M.R.C.S.E., of a daughter.

TRESDIDER.—April 28, at Dubbo, N. S. W., the wife of Harry Tresdider, M.R.C.S., England, L.R.C.P. London, of a son.

WEBB.—On the 29th April, at South Brisbane, the wife of Dr. W. S. Webb, of a daughter.

WHITAKER.—On the 23rd May, at North Melbourne, the wife of J. Whitaker, M.D., of a son.

MARRIAGES.

GAULT-SCOTT.—On the 8th May, at West Adelaide, by Rev. J. C. Hill, Arthur H. Gault, M.B., of Lower Mitcham, S.A., to Mary R., daughter of John Scott, Esq., Drumclaph, Tyrore, Ireland.

LANGHORNE-GLEN.—On the 22nd May, at St. Matthew's, Kensington, Thomas Langhorne, M.R.C.S. Eng., of Millicent, S.A., to Caroline Jane, third daughter of Geo. Glen, Mayurra.

MEREDITH-WATERS.—April 20, at St. Philip's Church, Sydney, John B. Meredith, L.R.C.S.E., of Raymond Terrace, N. S. W., to H. Evelyn, youngest daughter of the late T. G. Waters, of Monasterabin Co. Kildare.

SWIFT-PEACOCK.—On the 23rd April, at Christ Church, North Adelaide, Harry Swift, B.A., M.D., Cantab., to Kate Marian Lilian, daughter of the late Joseph Peacock.

DEATHS.

DIXON.—On the 14th May, at the residence of Dr. Niesche Adelaide, Emma Ann, wife of Hartley Dixon, F.R.C.S., aged 54 years.

FLETCHER.—April 16, at "The Glen," Bondi, Sydney, David Fletcher (dentist, 52 Wynyard-square, Sydney), aged 75 years.

REPORTED MORTALITY FOR THE MONTH OF APRIL, 1890.

Cities and Districts.	Population.	Births Registered.	Deaths Registered.	Deaths under Five Years.	Number of Deaths from									Child-bearing.
					Measles.	Scarlet Fever.	Croup and Diphtheria.	Whooping Cough.	Typhoid Fever.	Dysentery and Diarrhoea.	Phthisis.	Heart Disease.	Cancer.	
N. S. WALES.														
Sydney	128,880	322	184	56	...	...	7	2	7	7	25	17	6	1
Suburbs	252,850	868	325	148	1	1	9	2	14	13	31	14	9	8
NEW ZEALAND.														
Auckland	33,307	68	22	5	...	...	1	...	2	1	1	...	3	...
Christchurch	17,116	26	13	5	...	...	...	1	...	...	1	...	3	...
Dunedin	24,168	43	29	5	...	...	...	...	2	2	4	1	...	...
Wellington	31,028	95	46	16	...	...	1	...	7	7	5	4	.	...
QUEENSLAND.														
Brisbane	51,689	198	93	29	}	4	8	1	1	9	15	7	4	...
Suburbs	21,960	136	29	22										
SOUTH AUSTRALIA.														
Adelaide	44,581	...	...	...	...	...	...	...	...	...	...	...	...	...
TASMANIA.														
Hobart	35,806	89	80	20	...	...	2	...	1	4	3	9	4	...
Launceston	22,039	51	36	13	...	...	...	...	3	...	2	5	...	...
Country Districts.....	94,335	235	92	...	...	...	2	2	1	7	...	...	...	...
VICTORIA.														
Melbourne	75,400	161	133	} 355	...	3	60	1	63	24	114	41	28	7
Suburbs	362,385	1,317	840											

METEOROLOGICAL OBSERVATIONS FOR APRIL, 1890.

STATIONS.	THERMOMETER.					Mean Height of Barometer.	RAIN.		Mean Humidity.	Prevailing Wind.
	Maximum Sun.	Maximum Shade.	Mean Shade.	Minimum Shade.			Depth.	Days.		
							Inches			
Adelaide—Lat. 34° 55' 33" S.; Long. 138° 36' E.....	...	...	...	...	...	...	...	...	...	...
Auckland—Lat. 36° 50' 1" S.; Long. 174° 49' 2" E.....	135	72	62.8	50	...	...	5.520	18	74	...
Brisbane—Lat. 27° 28' 3" S.; Long. 153° 16' 15" E.	144.8	81.8	67.6	55.4	30.091	...	10.319	19	77	8.
Christchurch—Lat. 43° 32' 16" S.; Long. 172° 38' 59" E.....	131.4	80.6	56.7	32	...	...	.414	4	65	...
Dunedin—Lat. 45° 52' 11" S.; Long. 170° 31' 11" E.....	122	78	54.3	38	...	...	1.252	14	80	...
Hobart—Lat. 42° 53' 32" S.; Long. 147° 22' 20" E.....	...	74	56.9	38.8	30.042	...	1.52	7	79	...
Launceston—Lat. 41° 30' S.; Long. 147° 14' E.....	...	74.9	57.6	32.9	30.114	...	2.40	8	78	...
Melbourne—Lat. 37° 49' 54" S.; Long. 144° 58' 42" E. ....	...	87.5	59.7	40	30.105	...	1.82	6	...	...
Sydney—Lat. 33° 51' 41" S.; Long. 151° 11' 49" E. ....	...	75.6	63.7	49.8	30.168	...	2.46	15	74	S.W.
Wellington—Lat. 41° 16' 25" S.; Long. 174° 47' 25" E.....	135	72	59.4	43	...	...	3.713	11	73	...

A GOOD HINT.

REFERENCE to the long lists of exceptional testimonials on the use of "Vinolia" in skin treatment that we have published from time to time in the various medical journals will reveal that besides proving beneficial and frequently curative in Eczema (always apparently relieving the itching at once), it is reported to be useful in Acne, Comedones and Psoriasis. At first sight this may appear strange; for, as "Vinolia" is simply a pure antiseptic emollient, it seems difficult to understand how it could be of much use in the last-named affections; but where there is considerable inflammation of the skin, it would be probably difficult to prescribe anything more serviceable than "Vinolia." By adding a little calomel to each ounce of it, dermatologists say they obtain in Acne very striking results. By the addition of chrysophanic acid to it (say, 7 or 8 grains to the drachm), it is reported to have cured Psoriasis of years standing. We would add that a short time ago a medical man reported a case of Eczema of twenty-five years standing which had resisted all other treatment, but was completely cured with "Vinolia" inside of three months. An application for the skin that is safe, bland, cleanly, and gently alterative to the skin is a boon to the nursery, and physicians who have prescribed this plastic emollient cream for the nursery write to us that "It is simply invaluable," "Eminently successful," &c., for redness and roughness of the skin, abrasions, insect bites, and itching from all causes. "Vinolia" is now a most popular application with all the leading medical men.

We are just bringing out a pamphlet on the "Hygiene of the Skin and Hair," dealing concisely with the subject of soaps, and giving an analytical report, and journal and medical reports, upon "Vinolia" Soap, which contains free fat instead of free alkalies. We are also bringing out a new pamphlet, giving the fullest information obtained from most reliable sources upon "Vinolia" itself. Copies of these pamphlets we shall be pleased to supply, with samples of "Vinolia" and "Vinolia" Soap to any medical man in Great Britain or the Colonies, post free, upon request.

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AUSTRALASIAN MEDICAL GAZETTE.

ORIGINAL ARTICLES.

A CASE OF HYDATID TUMOUR OF THE BRAIN—REMOVAL—RECOVERY.

BY JAMES GRAHAM, M.A., M.D., HON. ASSISTANT PHYSICIAN PRINCE ALFRED HOSPITAL, SYDNEY, AND C. P. B. CLUBBE, M.R.C.S.E., HON. ASSISTANT SURGEON PRINCE ALFRED HOSPITAL, SYDNEY.

C. G., aged 16 years, a male, born in Ireland but has lived in the suburbs of Sydney since he has been in this country—a period of 12 years.

His father states that he was a strong, healthy child, bright and active, and has been, up to the present, free from any form of serious illness, except when at the age of 10 years he fell over a rock a distance of 12 feet. He then lay unconscious for two days with his head drawn towards the right side. A few days afterwards he recovered, apparently without any bad effects from his fall, and has enjoyed good health up to the time of his present illness, which he dates from Christmas last.

He left school at the age of 14, and has been employed since in driving a wood and coal cart. His employer states that the boy was an intelligent and reliable servant, but that for several weeks before he was laid up he noticed that his memory was getting bad, and that he seemed dull and depressed.

The patient first complained of severe frontal headache after waking from a good night's rest, and on getting up felt giddy and sick. Everything seemed misty before him, and he noticed shortly afterwards, during the same day, that he was quite blind in his left eye.

An attack of headache and vomiting confined him to bed for four days, and on getting up he said he felt much better only his sight was very dim, and he found he could not lift his legs as easily as he had been used to do. For about two weeks afterwards his sight seemed to improve, but the weakness in his legs increased. He noticed also that he could hardly use a knife with his right hand.

STATE ON ADMISSION.

The patient can give an intelligent history of his own health. He is well nourished and robust. He speaks slowly but distinctly, and the account he gives of his present illness is accurate when compared with his father's statements. His eyes are prominent, the pupils widely dilated, and react very feebly to light. He has a faint percep-

tion of light in the right eye, but the left is totally blind.

Hearing, taste and smell are normal. He walks like one steadying a weight on his head, and leans slightly towards the right side. He drags the right leg slightly, and he has greater power of grasp with his left than with his right hand.

Superficial and deep reflexes are not altered, neither are sensation and muscular sense.

OPHTHALMOSCOPIC EXAMINATION.

No paralysis of external ocular muscles. Both discs are in a condition of post-neuritic atrophy. The veins are large, the arteries considerably contracted, pointing to contraction of the exudation in the nerves. There has been more widespread exudation in the left eye than in the right. In the right eye it is confined to the disc and its immediate vicinity; in the left it is extended for some distance, obscuring the vessels in places.

Temperature, normal; pulse, 52; respirations, 15. Thoracic and abdominal viscera seem healthy; urine, normal. There is nothing unusual about the size and shape of the head. The scalp has been shaved, and careful examination failed to shew any localized bulging or thinning of the bones of the cranium.

The patient was kept under observation for some days, and meanwhile was given large doses of bromide and iodide of potash. It was noticed that he always lay on his back while sleeping, and that his breathing was slightly stertorous. He could only with great difficulty be roused from his sleep.

For some weeks he seemed to improve in his general condition, and took a lively interest in things about him. His power of walking increased, and the weakness in his right arm seemed almost gone.

On the 17th of March the nurse reported that he had had a fit in the night, during which he moaned and struggled a good deal.

On the following morning he had complete loss of power in the right arm and in both legs; he had also an attack of headache and vomiting. The left eyelid slightly drooped, and the face was drawn a little to the left side. He lay in a drowsy condition for some days, and when questions were put to him could only reply in monosyllables after some interval.

In the course of a week after this attack he regained power and movement, but in walking the dragging of the right leg was very marked, and the strength in the right arm was very feeble.

Perception of light was quite absent in both eyes, and the pupils no longer reacted to light.

His mental condition had become much more obtuse, and mind and memory were practically a blank.

As it was evident that the pressure mainly involved the left motor area of the brain, and that the symptoms of a tumour in this region had become much more pronounced Dr. Graham determined to submit the patient to operation without delay.

Mr. Clubbe conducted the surgical treatment of the case. After taking the usual precautions to render the scalp aseptic he trephined over the spot corresponding to the upper portion of the fissure of Rolando. In ascertaining the depth of bone which the instrument had reached the quill suddenly passed through the dura mater, and its withdrawal was followed by pulsating jets of clear fluid. On removing the button of bone, which was thinned to about one-sixth of an inch, the exposed portion of the dura mater was found thickened, and on opening it a quantity of clear fluid escaped. A light reflected through the opening made shewed a collapsed hydatid cyst lying at the bottom of a large cavity. This was easily seized with a pair of forceps, and removed by gentle traction. The portion of the brain exposed shewed that the pia mater was intact; from the presence of the cyst the brain substance corresponding to the motor area was bevelled into a cup-shaped cavity. It was evident that the hydatid had grown from the arachnoid membrane. The brain, while exposed to view, made no attempt to expand. The cyst measured four inches in diameter, with a fluid capacity of 19 ounces. The fluid gave the ordinary reaction of hydatid fluid. There were no scolices or daughter cysts. The interior of the hydatid wall was sacculated at different points. There was no evidence of an ecto-cyst in the seat of growth. The cavity was gently irrigated with a solution of perchloride of mercury, 1 in 10,000, and the dura mater stitched, except at one spot where a drainage tube was inserted. A corresponding opening for the tube was made in the scalp, and the edges of the semi-lunar flap brought together. The dressing was serum gauze and antiseptic absorbent wool.

The history of the case after operation is briefly given as follows:—

First Day.—Patient awoke from the effects of chloroform $2\frac{1}{4}$ hours after operation; vomited a good deal during the night, but was not restless and complained of no pain. The dressing was removed twice during the night on account of its being soaked with fluid; temperature, 99; pulse, 116.

Second Day.—A large quantity of discharge, necessitating frequent renewal of the dressings;

evening temperature, 99.4; morning, 99.2; at 6.45 a.m. had a convulsive fit lasting about a minute; constant twitching of both sides of the body and of the muscles of the left side of the face; drainage tube shortened 3 p.m.; when dressing the head noticed that the fingers and thumb of the right hand were firmly flexed, and that there were constant twitches in the muscles of the right forearm and occasional spasmodic twitches of the right leg. The left leg was similarly affected, but in a less degree.

Third Day.—Is very drowsy; does not wake when head is dressed; temperature (morning), 99; evening, 99.8; still a large flow of discharge. The drainage tube seems compressed, and it has been removed; the scalp over the trephined opening bulges. On dilating the aperture with a probe a quantity of fluid gushed out in pulsating jets. The nozzle of a glass syringe was applied to the drainage tube and two ounces of cerebral spinal fluid withdrawn. The muscular twitching in the limbs is less marked, and disappears during sleep.

Fourth Day.—Patient slept well during the night, and the twitches in the right arm and leg are only occasionally noticed. There is still a large flow of fluid from the wound, two ounces being drawn off by the syringe through the drainage tube. The stitches are all removed. The wound has healed by first intention. The fluid removed examined; specific gravity, 1011 chlorides and a trace of albumen; no sugar.

Fifth Day.—Patient complains of some pain over the region of the wound; had a restless night; dressing soaked with fluid; temperature, 102; pulse, 120; respiration, 26; appears from expression of the face to have pain when the head is raised, but is too drowsy to speak; passes his water in bed; has no tremors or twitches; is quite unable to lift his right arm, but can raise both legs when the superficial reflexes are stimulated.

Sixth Day.—There is less oozing from the wound; morning temperature, 100.8; pulse, 120; respiration, 24; seems more sensible; can protrude the tongue when asked; still urinates in bed. The pupils are not so widely dilated, and both react to light. There is no return of sight; no power in right hand; can give a firm grip with the left.

Seventh Day.—Seems much improved and takes more interest in things about him. The scalp flap is raised and doughy to the feel. Clear fluid is still coming through an opening in the cicatrix.

Eighth Day.—There is no discharge from the wound and it is less puffy than yesterday. The patient seems much more cheerful and has made enquiries about his friends. Can raise the right arm a little but has no power of grasp with the

hand. Thinks he can see light, but the various tests applied to test his sight failed to confirm his impression that vision was returning.

Eleventh Day.—This morning patient seems very lively; wants to know when he can get up. Says he feels very well and shows his cheerfulness by whistling some of his old familiar tunes.

Temperature and pulse normal. The grasping power of his right hand has greatly increased; is now nearly equal to that of the left. The right leg has completely regained the power of movement. Vision tested with lighted taper, result negative.

At 2 p.m. complained of slight headache and vomited. Temperature suddenly rose to 102. The scalp wound is again puffy, there is slight oozing from a small aperture in the cicatrix. The opening in the scalp which was made for the drainage tube has completely closed.

Mr. Clubbe opened up the aperture with a probe, and with some difficulty passed it through the dura mater. A quantity of fluid escaped in a pulsating jet. An opening was also made through the scalp over the centre of the trephined opening, and a probe passed into the brain cavity.

Twelfth Day.—Temperature 103; pulse 108; respiration 31. No oozing has taken place through the wound. Patient complains of pain in the wound and winces when it is touched. Scalp flap is still puffy, and strong pulsation is felt when the finger is pressed on the wound. About two drachms of fluid escaped when the probe was inserted into the aperture. A small drainage tube again inserted.

Two p.m.—Patient has lost all interest in things about him, cannot reply to any questions and makes no sign or expression of pain when being dressed. Oozing copious since the drainage tube was inserted.

Fourteenth Day.—Is much more conscious; temperature 99.9; pulse 96. Power returning in the right arm. Answers questions readily and says he feels "all right." Pupils dilated and react to light. Drainage tube removed. Dressings renewed frequently on account of oozing, which is still excessive.

The patient from this time began to make steady improvement. He gradually but completely regained power in his right arm and leg. At the end of six weeks he was allowed to get out of bed and to begin walking in easy and short stages. In a day or two the habit of walking by himself became quite easy, and now eight weeks from the operation he is quite smart and active on his legs.

There is also a marked improvement in his mental condition, his memory, which seemed to

become obliterated from the time of the operation, has now returned and he can recall facts and dates connected with his illness; as the patient puts it, "he feels all right, and is only waiting for his sight to come back."

The protrusion of the eyes, which was so well marked before the operation, has nearly all disappeared. The pupils are normal in size and readily react to light. He says, when asked if he can see, that daylight appears to him like a red light, but that at night everything is black. No positive evidence of returning vision has been manifested, and the structural changes in the fundi remain unaltered.

Remarks.—This case has the interest attached to it of being the first recorded recovery in Australia of cerebral hydatid.

The differential diagnosis of a hydatid tumour in the brain is generally a matter of great difficulty, unless the cyst has absorbed portions of the bony wall so as to lead either to bulging or absorption of part of the bone over the seat of growth, as occasionally happens.

The symptoms must vary with the size and position of the tumour, for the hydatid is found in the brain in all its parts, and also in the membranes.

The chief features of the disease which have been described in the cases recorded are:—

1st. That the greater number of patients affected were in the second or third decade of life, the average age being twenty-one years.

2nd. Hydatid tumours of the brain have been most commonly found in male subjects.

3rd. The seat of growth is usually in one of the spheres of the cerebrum, and most frequently in the right.

4th. They are rarely found in the cerebellum, even when the relative sizes of the brain are taken into account, and the liability of this part of the brain to be the seat of the various forms of growth, notably the tubercular.

5th. The most usual form is a single cyst, without progeny or an ecto-cyst.

The most commonly reported symptoms have been headache, vomiting, vertigo, blindness, and hemiplegia.

Davies Thomas states that hydatid disease occurred in the brain in 4 per cent. out of 2,000 cases recorded of the disease in various organs of the body. He also tabulates a list of 97 cases which are published in the first series of the "Transactions of the Intercolonial Medical Congress."

It has also been pointed out that the symptoms in this disease are often intermittent in their character, with now and then an intensified recurrence; that blindness, which has usually

been present, no matter in what particular region the cyst was found growing, often developed suddenly, and that in those cases where the blindness was at first unilateral the cyst was always found on the same side.

The disease in this region is often as erratic in its symptoms as it is in its seats of growth, and so may baffle the most skilful clinician. Thus in Dr. Gee's case, recorded by Davies Thomas, headache was the only symptom complained of, even when the cyst was found to be the size of a turkey's egg and was situated in the middle lobe of the left hemisphere. The pain is sometimes referred to the region of the tumour.

Dr. James Graham recently assisted Dr. Watson Munro at the *post mortem* examination of a patient aged seventeen years, whose symptoms had been those of cerebral tumour, not sufficiently marked, however, to enable it to be defined or localized.

There was sudden loss of sight, convulsive seizures, and severe paroxysmal pain confined to the back of the head. A hydatid cyst the size of a hen's egg was found in the right occipital lobe of the cerebrum. Three small hydatid tumours were also found in the right lung.

In the case of a girl aged 16, in Prince Alfred Hospital, who had the symptoms of a tumour of the cerebellum, which was thought in all probability to be of the nature of hydatid, Dr. Graham at the *post mortem* examination found a tumour of the nature of a glioma and the size of a walnut situated in the left side of the cerebellum. In each lung there was a small hydatid full of daughter cysts undergoing calcareous degeneration. The diagnosis of hydatid of the brain was strengthened from the circumstance that the patient lived in a district where the disease was known to be common, and the fact that the *post mortem* showed her to be the host of two cysts justified the conclusion arrived at.

In all suspected cases of hydatid tumour of the brain the scalp should be closely shaved and careful examination made of the bones of the skull. In one case reported in the journal by Mr. Hankins, the patient, who was thought to be purely epileptic, died in one of his seizures, and at the *post mortem* a hydatid was found in the right side of the cerebrum; a part of the parietal bone covering it was almost as thin as paper.

In Davies Thomas' list of over 90 cases of cerebral hydatids three recoveries are recorded, and in one of these the termination of the case was not exactly known, though a cure is credited.

In the one case cited by Davaine (1836), the cyst perforated the cranium and a small puncture was made in the scalp, through which the hydatid escaped; and in the other, reported by

Odile (1884), the cyst perforated the base of the skull and the patient passed vesicles through the nose and mouth. In the third case, where the ultimate result was unknown, the bone was perforated above the outer angle of the right orbit, and there was a second protrusion in the line of the coronal suture, which was incised and the cyst contents removed.

ON THE VALUE OF ELECTRICITY IN THE TREATMENT OF ARTICULAR DISEASES.

By CHEV. V. MARANO, M.D., &c., SYDNEY.

My reason for bringing under your notice this evening the history of a few cases of diseases of the joints treated by electricity, is the desire on my part that the beneficial effects of the electric current in joint affections should receive regular and general recognition. In doing so I will be as brief as it is consistent with clearness, and will commence by relating you the history of each case.

My first case dates back to July, 1884, and was that of a married lady aged 28, who after exposure to cold and damp was seized with very severe pain in her left hip, accompanied by high temperature (101°-103° F.), and much constitutional disturbance. The hip joint was much swollen and hot, the skin cedematous down to the middle of the thigh, which was slightly flexed and abducted, and any attempt at moving the limb gave the most acute pain. The case was one of acute arthritis of a severe form. I shall not detail the treatment used for the first two or three weeks, but only state that several consultations had to be held, method after method tried to relieve the excruciating pain, which was fast exhausting my patient and could not be subdued even by often repeated hypodermic injections of morphia, &c. But these remedies did not overcome the constant struggle going on between the adductors muscles and the over-distended capsule. The muscular contraction of the adductors almost amounted to contracture, and prevented any attempt at extension and eversion, and, therefore, to accommodation of the joint to the increased effusion. Being so convinced, I decided on using the faradic current. The effect was simply surprising, and by continuing its use from five to ten minutes two or three times in the twenty-four hours I was able to obtain an ankylosed joint without further trouble.

My second case is that of a young gentleman, 19 years old, a student for the law, who in November, 1887, while wrestling, his left foot was caught in a rope, tripped and, as a consequence, had sub-

luxation of the left knee. Synovitis followed, and was treated with the ordinary methods. The joint, however, remained weak, and in 1888, after a similar accident, the subluxation and consequent synovitis were renewed and similarly treated; but the joint was left much weaker, the semilunar cartilage slipping out of its place very easily. On the 29th November, 1889, I examined for the first time his knee-joint, which was larger than the sound one by nearly two inches, and gave great crepitus during any movement. There was localized pain in two or three places round the joint, distinct fluctuation, and great lameness. The usual treatment with revulsives, strappings, elastic bandages, &c., having proven of no avail, I decided in treating my case by electricity. I first used the galvanic current by means of large sponge electrodes, the anode on the painful spots, of ten to twenty minutes duration, and after a few sances the faradic current was brought in requisition and a few times the two were combined. By the 21st of the following December my patient was able to leave for the country, his diseased joint being perfectly restored to health. The galvanic current was most telling in alleviating the pain and causing absorption of the inflammatory exudations, while the faradic and galvanofaradic were most invigorating, removing that feeling of weakness and uselessness of the limb so marked before the treatment was commenced and so characteristic of such affections.

My next case is that of a young lady, aged 17, who first came under my care on the 19th August, 1889, suffering from morbus coxarius of the left hip at the beginning of the third stage. There had been rupture of the capsule with escape of the products of inflammation into the cellular tissues and with crepitus. The treatment was conducted with extension and then Thomas' splint, and adapted internal remedies. The case made a steadily satisfactory progress, and in April last all crepitus had disappeared, and the movements of the joint were almost all perfect. Yet there was still a considerable enlargement of the joint and a certain amount of contracture of the adductors. I resolved therefore to help the absorption of the inflammatory products and restore to the muscles and other tissues involved their normal state by the use of the faradic current. My patient was very fearful of it and I could only coax her in using same by promising that if after a week there was no improvement in the size of her hip, the treatment would be discontinued. Large sponge electrodes were used, and a current as strong as she could bear for from 10 to 15 minutes twice a day. I had no necessity at the end of the time of coaxing my patient any longer, the size having diminished considerably,

and the movements having become easier and freer every day. The last I heard from my patient was that she felt stronger on the diseased limb than on the sound one. The current was applied by her mother, she living away from town.

My last case, though not one of articular disease, is that of a young lady of 18, who fell, while skating about three years and a-half ago, heavily on her left hip, which was very much swollen for some time, and from which the discoloration caused by the bruise did not disappear but a year or two later. A swelling the size and shape of an egg, and having the consistency of a fat tumour, situated in the upper and outer part of the thigh was left. At first this swelling had a deep indent in it, running from above downwards and almost dividing it into two segments. She had great pains when walking, while dancing and skating were not possible. The thigh over the tumour measured nearly one inch and a-half more than the sound one. I diagnosed to be effusion in the fascia lata where it receives the fibrous expansion from the gluteus maximus muscle. Having the ordinary methods of revulsives, etc., being tried without any benefit, and an operation having been advised, she consulted me. I used a galvanic current of about 20 m.m., and the improvement commenced from the first seance, the pain disappearing and the movements becoming normal. After six or seven applications the thigh measured slightly less. The skating season, however, set in, and my patient being now able to indulge in her favourite pastime, left treatment, and now, after nearly three months, still keeps well, though the enlargement has but little diminished in size.

Gentlemen,—In all the above sketched cases and similar affections we meet with the following pathological conditions, viz: the products of inflammation present in the parts primarily attached as well as the surrounding tissues; spasm of certain muscles; irritation of the branch or branches of nerves supplying the affected part; vaso-motor disturbances of same; and, lastly, lesion or lesions of a distant part from the seat of the disease in consequence of an obscure sympathy between the said parts. To combat such conditions we use rest and sedatives, pressure by bandaging or strappings, and counter-irritants, not mentioning, of course, the specific remedies which we possess against some of these pathological conditions.

It is not likely that electricity will supersede salicylic acid in the treatment of acute polyarticular rheumatism, notwithstanding the proven facts that faradization for from 5 to 10 min. with a powerful current, the sensitiveness to this current being

very much lowered in the affected joints, reduces the increased temperature of the joint to normal, moderates the pain for some hours, and brings about a short and uncomplicated course of the disease. Yet there are cases where you will find in this agent a most brilliant and sure palliative, chiefly, in my belief, for its antispastic action.

In subacute and chronic cases, however (mono or polyarticular chronic rheumatism, arthritis deformans, stiffness of the joints following sprains, dislocations of or fractures near the joints, periartritic swellings and the like,) electricity stands unrivalled, and if you consider for a moment the *modus operandi* of each remedy ordinarily employed and that of electricity, you cannot help seeing the latter's superiority. By immobilization of the joint and pressure we aim at encouraging the absorption of exudates by increasing the absorbent superficies and avoiding fresh irritation. But if we make the layer of fluid thinner we interfere considerably with the superficial circulation of the part so pressed, and cause wasting of the muscles by inactivity. By the counter-irritants, from simple stimulating liniments to the moxa; we draw chiefly for help on the superficial circulation; but, as daily experience teaches us, it is a very long and tedious process, often unsuccessful because it cannot reach the tissues deeply situated.

The available effects of the current, you are well aware, are many and varied, viz., catalytic, cataphoric, electrolytic, osmotic, exciting, modifying, refreshing, antispastic, one and all at your disposal and under absolute control; one and all of less or more value for the removal of the diseased conditions under consideration.

I have purposely selected from amongst many the few cases afore-sketched because in every one of them the ordinary means had signally failed after long and persevering trial. I believe that the current has not been employed by others for cases of hip-disease, but, used or not, I can confidently recommend you to employ it under similar conditions, and you will have none but gratifying results.

My fourth case is noticeable for the fact that, although the swelling itself was but slightly modified in its size and shape, yet the pain, radiating from it and interfering with the function of the limb to a very great extent, disappeared and its function was restored. Similar fact is to be observed in the treatment of sprains, acute or chronic, and suggests the great part that this symptom, pain, plays in similar morbid processes by itself becoming a cause of further mischief.

PROBATORY LAPAROTOMY — FAL-LACY OF PRELIMINARY PUNCTURE.

By J. B. ROSS, M.D., OF WARRNAMBOOL, VICTORIA.

THE main object in bringing these notes under the notice of practitioners is to demonstrate how careful one has to be as regards the diagnostic importance of preliminary puncture, and the history of case as given by patient.

Mrs. McD. consulted me for a tumour in her left side. I was told that about November last year she became sick with diarrhoea and vomiting. At times she would pass blood with her motions. She took several doses of castor-oil but did not experience much relief. She then consulted a medical man, complaining of diarrhoea and pain in her side. After an examination she was told she would soon be alright. As the medicine prescribed "did not do her any good," she saw him again, and this time was informed she had broken a blood-vessel in her side.

Not satisfied with this explanation she consulted another medical man about Christmas. A tumour was detected and she was advised, after consultation with a brother practitioner, to desist from an operation.

About New Year she sought the advice of a third medical man, who informed her the tumour was not cancerous and *as big as an egg*.

In April last she consulted me. She was then suffering from occasional pains in her side, loss of strength, vomiting, and at times diarrhoea. At others an anal discharge was noticed, independent of fecation, and passed in the ordinary way. This discharge contained blood and sometimes a yellow jelly-like matter. Patient complained of getting weaker and losing her appetite.

Stat. præs.—Mrs. McD. is very stout, great corporation and abundance of subcutaneous fat, making palpation extremely difficult.

On examination I found a tumour reaching upwards to the false ribs anteriorly to about three inches from linear alba downwards to christa-ilei, patient being in a recumbent position. Posteriorly I thought I could put my hand behind it. The tumour felt elastic, apparently fluctuating, and of irregular surface.

On percussion I found absolute dullness over posterior part of tumour. The husband informed me that about New Year he could encircle the tumour, his fingers being arranged like a griffin's claw, and that he was sure it did not feel bigger than a good-sized egg.

From the history I received and my palpation I thought I had to deal with an ovarian cyst, the

pedicle of which, being twisted, causing rapid growth.

But I did not feel sure about the diagnosis, and proposed to follow the axiom, "cut open and see," with the intention of removing the tumour if possible, otherwise close the wound and leave it alone.

After some deliberation this course was decided on. Before the operation, however, I asked Dr. Miller, who kindly consented to examine the case with me.

In recumbent position the results were as before related; in semi-prone, suggested by Dr. Miller, the tumour was felt adjacent to the abdominal walls, and we were able to put our hands behind it. Upwards the false ribs prevented us from finding the margin, inwards and downwards it could be easily palpated. It seemed of hard consistence; I was unable to find anything like fluctuation.

On considering the diagnosis we thought we could leave malignant tumour out of the question on account of the rapid growth. Dr. Miller suggested hydatid tumour, remarking that he had met with rapid growing cysts before.

Some days later I made another examination and this time inserted a Pravaz needle in two different places, each place yielding a drop of clear fluid. Circumstances prevented microscopical and chemical examination. This result seemed to substantiate Dr. Miller's opinion, and I felt satisfied in giving a more favourable prognosis.

On discussing the case we had come to the conclusion that the tumour was adherent to some part of intestines, and had arranged operation accordingly. I made my preparations as if I had to deal with an ovarian tumour.

Assisted by Drs. Miller and Bett, I made the incision along the most prominent part of tumour, from false ribs down to crista-ilei. The external and internal oblique muscles were cut through separately under guidance of the director. The transversalis muscle was not seen.

Before slitting up the lumbar fascia both Drs. Miller and Bett assured themselves of the hard consistence of the tumour and its nodular character. All bleeding having been stopped, the fascia and peritoneum were opened. An abundance of subperitoneal fat prolapsed at once. No sooner was this removed when a coil of small intestines appeared; this was pushed back, so was another, and kept back by means of iodoformed gauze. I now found the colon descendents lying before the tumour. I inserted my finger into the abdomen, trying to remove it, but in vain. An attempt to remove it from the front had also to be given up. Any force to peel the colon from tumour had to be avoided, as this part of intestine

showed a morbid appearance. Under these circumstances we desisted from completing the operation.

The wound was washed and thoroughly dried, the fascia and peritoneum caught by the same suture of catgut. Before I had finished the patient vomited and one stitch gave way, which was put in again. On account of the great amount of subcutaneous fat I refrained from stitching the surface wound. Iodoformed gauze was put in and carbolyzed wadding finished the dressing.

No reaction whatsoever followed, although patient was very sick for two days from the effects of chloroform. Flatus passed next day, motion on third day. Temperature never reached above 99.4° Fahr.

Seven days later I removed the dressing and stitched the wound with deep silk and superficial catgut sutures. On removing the dressing nine days later I found *prima intentio*.

On palpation I found the tumour larger than when last seen, especially noticeable posteriorly.

I proposed another attempt to remove the tumour, but was refused.

Neither the urine or the anal discharges were ever examined, as I thought it of only small importance.

I refrain from going into a discussion on nature, locality, and origin of tumour, as these lines are only intended to warn against results from preliminary puncture.

The history of the case as regards size of tumour was very misleading.

A CASE OF SYPHILITIC DEAFNESS IN A CHILD.

By W. F. QUARRE, B.A., M.B., ETC.

On October 22 I was invited to see a child, D., a native of Scotland, who had been here for some three years. This child was extremely deaf in both ears, more especially the left, hearing her mother speak only in the right ear, and being quite impervious on both sides to the tick of a loud Waterbury watch. While at home in Scotland this child had suffered from a severe attack of interstitial keratitis which resisted all remedies until she left on a long sea voyage. The corneæ are now quite lucid in appearance, but the eyes are myopic. There is, however, no sign of any iritis. The child is at present about 12 years old, and is stunted for her years, but there are no scars of any kind on her body. The teeth are very peculiarly pegged, with long vertical ridges in them; the cutting edges are much narrower

than the roots, and are notched with small oval elevations rising out of the notches. This condition exists on all the upper and lower incisors, and arose, the mother says, from a severe inflammation of the gums from which the child was suffering at the time when the second teeth were coming through. The soft palate and nose are quite sound, but there is a little naso-pharyngeal catarrh. No adenoid growths are present, and the passage is quite free to air. The external meatus on both sides are quite healthy; both membranes are extremely concave and dull, the manubria lying far backwards and almost out of sight. When inflated by the eustachian catheter the membranes are seen to be quite flaccid, though the manubria remain drawn back; the tubæ are, however, quite patent to the current of air on both sides. Politzerisation is ineffective, but this I attribute rather to the difficulty of making the child understand what has to be done than to any paralysis of the tubal muscles. The history of this affection of the ears is one of 15 months' standing. It came on rapidly to a high degree without pain. Although it was under treatment at its early stage for a period of about six months this treatment seems to have been inefficient, being confined to the local use of Politzer's bag and the internal administration of iodide of iron. No attempt was made at that time to apply to the tympanic mucous membrane any stimulating application, or to the mastoid process any inunction; and I am inclined to believe, from the result of my own treatment at a much later period—slight though it was—that if such attempts had then been made a beneficent change would have occurred of a truly surprising nature.

There is in my mind no doubt whatever of the syphilitic nature of the case. The stunted growth, the history of keratitis, which went away before the incidence of the ear trouble, the extreme degree of deafness manifested early in the progress of the case, the rapidity of the progress and the freedom from pain, the affection of the naso-pharynx, all these are points which Pierce of Manchester has well insisted upon as characteristic of inherited syphilis. And when to these are added the pegged teeth, and the story of desertion by a father, the judgment is only too plain. The state of the membranæ themselves is certainly by no means characteristic, but that is an unimportant matter when we remember how rarely these structures exhibit any other than secondary changes due to a prior disorder of neighbouring tissues. Under the circumstances no expectation of benefit could arise without efficient local administration of mercury and the iodides, coupled with the use of pilocarpin hypodermically for the removal of the

specific labyrinthine exudations. And the unsatisfactory result in this case after their use proves not so much their inadequacy as the need for attacking such cases at the verge of their onset. If after five weeks of this treatment the child could be made to hear the harmonium in church, this is a very clear proof of its value in such cases as have been taken at an early stage. This case further brings out the difference in seriousness of import between syphilitic deafness and some kinds of syphilitic blindness.

Hyde Park, Sydney, June, 1890.

EXPLORATORY PUNCTURE IN HYDATID CYSTS, WITH NOTES OF A FATAL CASE IN MULTIPLE HYDATIDS OF THE LIVER.

BY JAMES GRAHAM, M.A., M.D. (EDIN.),
HONORARY ASSISTANT PHYSICIAN PRINCE
ALFRED HOSPITAL, SYDNEY.

T. K., aged 66 years, sought advice through the Hospital Outdoor Patients' Department for symptoms of troublesome indigestion. He had been ailing for six months. On examining him I drew his attention to a marked bulging over the region of the liver extending down to the umbilicus. It had never occurred to him that there was anything amiss in the swelling, and he attributed it to natural causes. In other respects he looked hale and hearty. The liver dulness extended from the level of the nipple to the umbilicus. Between these levels it seemed to fill the whole space. The lower margin of the liver was sharply defined and easily felt. There was no jaundice, ascites or prominence of the veins of the abdomen. The whole surface of the liver had an elastic feel. The heart was enlarged and the pulse strong.

He was admitted into hospital on the 8th of May. An exploratory needle was inserted by the resident physician into the most prominent part of the swelling to the right of the middle line. Nothing but blood was obtained, however, and it was again inserted into the middle line, when some clear fluid containing scolices was obtained. About a minute afterwards the patient was observed to gasp; his respiration became rapid and the pulse at the wrist imperceptible. He broke out into a copious cold sweat. He rallied somewhat after the administration of stimulants and the hypodermic injection of ether. In the course of three hours he complained of severe pain in the abdomen. He had two rigors, in which the temperature rose to 101, and some slight attacks of vomiting. His most distressing symptom was breathlessness.

He was carefully watched during his condition of collapse; stimulants were administered freely, and two small doses of atropine injected, in all $\frac{1}{16}$ gr.

He gradually got weaker in spite of every effort. His respirations were of a sighing, rapid and distressed character; there was no rash; the face was of a dusky, livid colour; the extremities cold; the pulse remained rapid and almost imperceptible. He died 14 hours from the onset of his symptoms.

The *post mortem* examination shewed that the liver was enormously enlarged, and that the enlargement seemed uniform throughout; it weighed $11\frac{1}{2}$ lbs. Deeply imbedded in its substance were three large hydatid cysts, wide apart from each other. The tracks of the needle puncture were visible. In each case the needle had penetrated about two inches of liver tissue before the cyst had been reached. The cysts were adjacent to the surface of the liver only at its upper and posterior part beneath the diaphragm—a position inaccessible by exploratory puncture. In the peritoneal cavity there was no sign of inflammatory trouble; about half-a-pint, however, of blood-stained fluid was obtained at the most dependant part, which had probably escaped from the cyst as a result of the puncture. Three small hydatids were found in the left lung, one situated anteriorly at the inferior edge of the superior lobe, the other two at the posterior part of the base of the inferior lobe. The heart was hypertrophied and dilated.

Several cases are on record where death has followed a simple exploratory puncture of an abdominal hydatid.

In *The Lancet* for August, 1875, a case is recorded by Dr. Martineau where a patient became faint and sick, and died after a fine trocar had punctured a small cyst in the liver.

In "Bartholomew's Hospital Reports," vol. xvi., there is the record of a case where the patient died suddenly after the trocar had penetrated a cyst in the right lobe of the liver.

It is also a matter of common occurrence in this disease to witness a series of distressing symptoms follow a mere puncture in this region—high temperature, intense abdominal pain, dyspnoea, vomiting and rigors. In some cases I have noticed these symptoms to persist for three or four days, and to give rise to grave anxiety.

In *The Lancet*, January 15, 1887, there is a case recorded where the patient, after being tapped for a cyst in the liver, was seized with faintness, dyspnoea and vomiting; the extremities became cold, the radial pulse almost imperceptible, and the heart sounds almost inaudible.

Dr. Thomas ("Hydatid Disease") refers to a case where, a few minutes after tapping a cyst of the spleen, the face of the patient became dusky, hands and feet cold, the radial pulse imperceptible, and the respirations laboured and hurried.

It seems hardly a satisfactory answer that shock is sufficient to account for these distressing symptoms occasionally noticed. If such be the sole cause we should expect to find the condition more frequent, for the insertion of exploratory needles is a matter of everyday occurrence.

Reflex inhibition of the heart's action exerted through the sympathetic might account for the condition of collapse, but we have still to explain the persistent high temperature, the pain, the appearance of the rash, etc.

What adds to the difficulty is that fresh hydatid fluid extravasated into the peritoneal cavity is not in itself an irritant, as I have satisfied myself from experiments on dogs, so that it is probable that the cause is to be found in the fluid itself being absorbed, and some principle in it acting as a poison. The experiments of Roy, of Cambridge, would seem to support this theory.

An exploratory puncture into an abdominal hydatid may lead to a fatal result from hæmorrhage. The vessels in the fibrous ecto-cyst are often found large and tortuous, and may easily be transfixed in the passing of a needle. I recently assisted at an operation on a large hydatid of the liver, where the abdominal incision was made down to the cyst-wall before any exploratory puncture had been made. It would have been impossible to enter the cyst with an exploratory needle from the skin without transfixing a branch of a large and tortuous plexus, which thickly covered the ecto-cyst.

I submit that the passing of a needle into an abdominal hydatid is an operation which should never be undertaken until the patient has been duly forewarned and the surgeon forearmed. This precaution is doubly necessary in pulmonary hydatids.

I have the records of three cases of hydatid of the lung where alarming suffocative symptoms followed exploratory puncture, and where in each case the patients seemed snatched from an untimely end by free opening of the chest cavity and removal of the cyst and its contents.

I have a growing conviction that the proper time and place for the exploratory needle, in dealing with the tumours of internal organs which are palpably hydatid, is when the surgeon requires confirmatory evidence after he has made his first incision and before he opens into the sac.

PROCEEDINGS OF SOCIETIES.

NEW SOUTH WALES BRANCH OF THE BRITISH MEDICAL ASSOCIATION.

AN unusually large meeting of the branch was held in the Royal Society's rooms on the 6th June. The President (Mr. T. G. Hankins) occupied the chair. There were about 50 members present. The chief business was the following motion, by DR. ODILLO MAHER,—"That in the opinion of this society it is desirable that the Sydney Hospital be completed, and that a deputation be appointed to wait on the Colonial Secretary and urge the necessity for so doing." The PRESIDENT suggested that the motion be divided into two parts, the first to read,—"That in the opinion of this society it is desirable that the Sydney Hospital be completed;" and that the second division stand as a separate resolution altogether, for he thought it expedient, before the question involved in the second part of the motion was carried, that there should be a perfectly representative meeting, and if a majority decided in favour of it the majority should be a large one. Thus the reason for going before the Government as a deputation would be considerably strengthened.

DR. MAHER said that he would move as a first stage—"That the present portion of the Sydney Hospital be completed," and in so doing remarked that it was his privilege to introduce to the notice of the meeting a subject so intimately connected with the well-being of the sick poor of this city, that it must necessarily command attention, and, he trusted, meet with favourable consideration. In the year 1879 the old Sydney Infirmary, having for many reasons been condemned, was, with the exception of the south wing, pulled down, and a weatherboard building erected for the accommodation of about 150 patients. The plans for the new hospital adopted by the permanent structure committee were submitted to sanction by the Government, and the general arrangements were approved of by the honorary medical staff. The building was started in 1881, and in 1883 the work was stopped by the Ministry of the day, who were opposed to its completion, he believed, on account of the expense. The basement and first story had been completed at a cost of £69,218 1s. 3d. Since then affairs have remained *in statu quo*, the patients had been accommodated in the south wing of the old infirmary and in the weatherboard building, the nursing staff in the Nightingale wing, the outpatients attended in a temporary galvanized iron building in the Domain, and that portion of the new hospital which had been erected was allowed to vegetate. Everyone must feel that seven years was quite long enough for such a condition of things to last, and that it was high time steps were taken to secure more appropriate accommodation for the sick poor. The weatherboard building, containing 150 beds, is as dry as tinder, and is built on pillars, which allow of a free current of air underneath. It was stated on high authority that if once it caught fire nothing could save it; and, although much had been done to afford the inmates means of escape in case of such an accident, it would be next to impossible to save all the weak and injured.

DR. CHISHOLM seconded the motion, and after some further remarks by Drs. Hodgson, Fiaschi, Quaife, M'Donagh, and Scot-Skirving,

DR. SYDNEY JONES said that as one who was opposed to the hospital being built on the present site, possibly the expression of opinion he formerly gave may have had something to do with the public impression that the profession were opposed to the present structure, and

on this point he desired to make an explanation. He had opposed the construction of a large hospital on the present site because it appeared that the requirements of the city would best be met by the erection of a small hospital for accidents and urgent cases; other cases would be better treated in the Prince Alfred Hospital, which was capable of indefinite expansion. His proposal had been, therefore, that a hospital of moderate dimensions for urgent cases should be erected on the present site. That view, however, was opposed at the time by the board of directors, and he condemned them then as he did now for undertaking so lavish a structure. They did not count the cost, and the result was that the building had come to a standstill, whereas, if they had fallen in with his view a small hospital would now have been built. Since, however, a building had been put up, or a portion of a building, on the present site, he was in favour of the completion of the portion already commenced. It was certainly an eyesore that a partially-erected building on so magnificent a site should be left in its present state. The requirements of the city were certainly different now from what they were when the buildings were commenced, by reason of the increase of commerce, &c. The present building, when completed, would not accommodate more than 200 patients, which would be a moderate-sized hospital, and one not larger than was necessary. He begged to support the resolution proposed by Dr. Maher.

DR. SHEWEN and DR. ELLIS also supported the resolution, which was passed unanimously.

DR. MAHER said with the permission of the meeting he would move the second part of the resolution,—"That a deputation be appointed to wait upon the Colonial Secretary, the deputation to consist of Drs. Hankins, Chambers, Goode, Fiaschi, Knagge, Sydney Jones, MacKellar, MacLaurin, Tarrant, Quaife, Brigade-Surgeon Williams, and the mover."

DR. ELLIS seconded the proposition.

The motion was carried unanimously.

DR. SCOT-SKIRVING read the following notes on a case of "Vasomotor changes in locomotor ataxia," and exhibited two patients suffering from the disease and who had been under the treatment of Dr. Skirving and Dr. Clune.

ON TWO CASES OF LOCOMOTOR ATAXIA, PRESENTING RESPEC- TIVELY VASO-MOTOR CHANGES AND CHARCOT'S JOINT DISEASE.

By R. SCOT-SKIRVING, M.B., PHYSICIAN TO
THE PRINCE ALFRED HOSPITAL AND
LECTURER IN CLINICAL MEDICINE IN THE
UNIVERSITY OF SYDNEY.

DR. SCOT-SKIRVING in demonstrating the features of these cases said: "I wish to bring before the notice of the Society two remarkable examples of certain rarer symptoms met with in loco-motor ataxia."

Case I. is that of a man of 35 years of age, who, as I believe, is an example of a very general vaso-motor paresis due to the central neural degeneration found in Tabes. The condition in this case forms a most complicated clinical picture. Let me briefly mention the most salient features.

- (a) You must be at once struck by the intensely cyanotic condition of his face and neck. This condition obtains in his faucial mucous membranes, and you will note it, when he strips, on his back, soles of feet, his palms and elsewhere.
- (b) He has an enlarged liver and a markedly enlarged spleen.
- (c) He has a little albumen in his urine, which is of a low specific gravity, but contains no tube casts.
- (d) I must ask you to accept my statement that he is without cardiac or respiratory disease, neither is there any evidence whatever of intra-thoracic pressure, neither has he suffered from syphilis, or malaria, or alcoholism.
- (e) Finally, he is inco-ordinate; has some of the sensory disturbances met with in sclerosis of the posterior columns. He has loss of knee-jerk; doubtful gastric crises; occasional spontaneous ecchymoses (tabetic) and curious local sweatings; no ocular signs; slight retroversion of his knee-joints and certain other symptoms, chiefly parietic, which render it probable that parts of the cord other than the external fasciculus of the posterior columns are involved in the degenerative process.

Viewing this case in its entirety and excluding any other cause likely to produce such symptoms, I submit to you that the cyanosis and the visceral enlargements are both due to vaso-motor paresis.

It may be that, as often occurs in spinal disease, we have actual organic changes in the kidneys. Still it seems also not unlikely that the albumenuria may owe its origin to the same cause which, I believe, causes the increase of size of liver and spleen.

Case II is one on which, I believe, we shall all agree as to the diagnosis. So far as I know it is one of the first perfectly typical examples of "Charcot's joint lesion" reported in the colony. We owe our thanks to my colleague, Dr. Clune, for permitting me to bring the patient before you.

Briefly his history is as follows:—

He is a Frenchman of 39 who has lived freely, had a hard life, and passed through a complete attack of syphilis eighteen years ago.

Four years ago certain sensory disturbances began to annoy him, pains and altered sensibility of the feet and legs. About three years ago, that is in an early stage in his neural disease, he one day found his left knee stiff and much swollen, and painlessly so. This passed away on keeping quiet, leaving the joint as you see, mobile and creaking with loss of its normal outlines, enlarged,

and with bossy articular ends. This, gentlemen, exemplifies what Charcot calls the "benign" form of the disease. About two years ago, apparently after an attack of enteric fever, the sensory symptoms became more marked, numbness over his thighs, chiefly the right, and, in addition, difficulty and incertitude in walking, especially at night. Some time after this he noticed that his right hip had rapidly swelled, it was not painful at first, though it became so afterwards; it did not stop him walking although the swelling extended right along the front of the thigh, even as the left is now. One day, while working, he felt his hip suddenly give way, and he had to give up work; in short, luxation of the partially-absorbed head of the femur had occurred, backwards and upwards. This dislocation you may note for yourselves. It exemplifies the "malignant" form of the disease (Charcot).

Eleven weeks after the onset the swelling had disappeared and left the joint as you see it.

His left hip was next attacked during last December, and has been larger than at present. When you come to examine him you will notice the enormous, cold, painless swelling, not only of the region of the joint, but of the whole of the front and sides of the thigh. You will also observe the intense fluctuation about the joint, and the fact that not only is the joint itself the seat of a hydrops, but that the tissues, perhaps the bursæ, round the joint are also similarly distended by fluid which aspiration has shewed to be serous, bloodstained, and which deposits a red granular sediment. I feel I ought in honesty to add one other clinical fact, and it is this, that the poor fellow suffers, in addition, from pulmonary phthisis. I mention this because some of my hearers may possibly view the joint affections as tubercular, a view I cannot hold, the onset and clinical history being opposed to all my experience of arthritic conditions due to tubercle. As to the locomotor ataxia itself, its existence is put beyond question by his sensory troubles, the absence of knee jerk, the presence of the Argyll Robertson phenomenon, and so far as his condition would allow detailed examination the evidence of inco-ordination.

At the conclusion of the reading of the notes DR. SKIRVING said he would like to have an opinion upon the diagnosis, and was desirous of having suggestions as to treatment. With regard to Dr. Clune's exhibit, he felt confident that the case was a genuine one of Charcot's disease. Concerning the swelling on the patient's left hip, he considered it due to intra-articular effusion. As Charcot had pointed out, there may be effusion inside as well as outside in the neighbourhood of the joint. Some years ago an attempt had been made to draw off the blood-stained fluid, which flowed easily at first, but was subsequently checked by red-coloured debris. The patient had been examined a great deal during the past

fortnight, and he therefore asked the members not to move the joint more than they could help.

The PRESIDENT invited discussion on the two remarkable cases brought before the meeting.

DR. RENNIE said, with regard to the second case, there were two points of interest. First, the antecedent history of syphilis several years before the onset of the ataxia symptoms; and secondly, the early period of the disease at which the joint affection, which was no doubt a true case of Charcot's disease, manifested itself. With regard to the first case, he thought the diagnosis of locomotor ataxia not proven, and that all the symptoms could be explained by a condition of peripheral neuritis, or rather peripheral nerve degeneration. There was no history of syphilis in this case, and the symptoms first manifested themselves some two or three years ago. But this was not inconsistent with the theory of peripheral nerve degeneration, and the loss of muscular power in both arms and legs was a point in favour of that view. As to the condition of the liver and spleen, if the enlargement were due to similar conditions of vasomotor paresis, he would expect to get more marked alteration in the urine. Though there was no clear history of any recognized predisposing cause of such affection, he was inclined to the view that the enlargement of liver and spleen was due to albuminoid degeneration, and the condition of the urine, viz., large amount with low sp. gr. and large amount of albumen, would point to a possible affection of the kidneys of the same nature.

DR. FIASCHI remarked that at one of the meetings of the Royal Society a case of locomotor ataxia had been presented, and which showed symptoms of Charcot's disease. The disease, however, was not advanced, and had not the characteristic appearance of the exhibit of Dr. Skirving. Some of those who were present at the meeting he referred to thought the case might be one of arthritis, and others stated that they had never seen a case of Charcot's disease. Dr. Skirving had now, however, brought before the meeting a typical case, showing that in Australia we could see a genuine case of Charcot's disease.

DR. SYDNEY JONES said it was quite true that he had remarked that he had never seen a case of Charcot's disease in the colonies. Now, however, he could say so no longer. The second case shown by Dr. Skirving was one in which the diagnosis was absolutely certain. He had had an opportunity in London, some years ago, at a meeting of the Clinical Society, to examine 10 or 12 cases. These bore a remarkable resemblance to exhibit before the meeting at present. Dr. Skirving had said that the joint affection which the patient exhibited was probably the result of tubercular disease. He (Dr. Jones) did not favour this theory. One never saw a tubercular joint in which the movement could be performed so freely, with the kind of creaking, and with the absence of pain as was the case with the patient. He did not think there was a shadow of a doubt that the second exhibit was a pure case of Charcot's disease, and the meeting was certainly indebted to Dr. Skirving for bringing it forward. In the first case, however, he did not think the diagnosis quite clear, though on the whole he was disposed to agree with Dr. Skirving. Only a day or two since he happened to light upon a short article in the *International Medical Journal*, referring to some cases which had been reported in Paris only last year. The cases, which were recorded as those of congestive venus diathesis, bore a remarkable resemblance to the symptoms exhibited in the patient brought forward by Dr. Skirving. Among other symptoms there were erythema, conjunctivitis, coryza, albuminuria, catarrh of the lungs, with blood expectoration and

abdominal pain. These cases were referred to as belonging to congestive venus diathesis.

DR. SKIRVING said, in reply, that to aid in the diagnosis of the disease, he had gone carefully into the question of peripheral neuritis, and there was an absence of tenderness along the walls of the affected nerves. He had also made careful examination, with a view to the discovery of other symptoms, with the result that the balance of evidence was in favour of the theory of locomotor ataxia with perhaps some involvement elsewhere. He was entirely unaware of the cases mentioned by Dr. Sydney Jones, and the meeting was certainly under an obligation to that gentleman for referring to them. The symptoms of those cases, so far as the condition of the blood was concerned, were almost exactly like the cases he had introduced.

DR. CHAMBERS, in introducing a patient, apologized for doing so, but as the case was one of general interest, and the patient was not likely to remain in Sydney long, he had brought the matter forward without notice. He said that the patient (who was present) had been married for several years, and had had two children, the youngest being 10 years of age. From that time she had been treated for ulceration of the womb. For six years she had been an invalid, and was unable to support herself. Although married, her husband was not one of the most faithful of men. The woman had been admitted into the Sydney Hospital in February last year, and when examined it was concluded that she was suffering from tubercular disease. He had kept her in bed, and treated her with all the ordinary forms of physic, and advised rest. At her urgent request he had her removed to the operating room, and subsequently opened her abdomen. He found the pelvis occupied by two distinct growths of great tenderness. After a great deal of labour and difficulty he succeeded in removing that on the right side. He had great difficulty in getting to the ovary and effecting its removal, inasmuch as the ovary and tube was anchored down in the bottom of the pelvis. The operation occupied over an hour. The patient had got considerably run down, and he thought it unwise to complete the operation then by operating on the left side, though he was not supported in this view by the medical man who had assisted him. The patient was sent to bed, and recovered fairly well, and by the end of April was comparatively free from pain. The patient was subsequently sent to a convalescent institution, and sufficiently recovered to be able to carry on her ordinary avocation of housekeeper. She became perfectly free from inconvenience and the mass in the left side quite disappeared. Her menstrual function was carried on with great regularity. He considered it of some service to bring such a case before the meeting, and he would like the members to ask the patient any question they thought necessary and he would answer them.

DR. COLLINGWOOD desired to know the nature of the mass that was removed from the right side.

DR. CHAMBERS said that the diseased tube that was removed was filled with soft gelatinous matter and pus.

DR. WORRALL remarked that he thought it unwise where there was pus to trust to its being absorbed, the surgeon who did so leant upon a broken reed; but in this case it did not follow, that because there was a pyosalpine on one side, that there might not be a hydrosalpine on the other, or simply chronic inflammatory matting, which would explain the subsequent disappearance of the mass.

DR. CHAMBERS explained that Dr. Worrall had assisted him at the operation, and had had an opportunity of examining the growth in the pelvis. He (Dr. Worrall) was anxious that the operation should be pro-

ceeded with, but the patient was so run down that it appeared dangerous to proceed to the other side with the operation. Concerning the pus, he thought that as much had been done as was justified by the powers of the patient.

SOUTH AUSTRALIAN BRANCH OF THE BRITISH MEDICAL ASSOCIATION.

ANNUAL meeting held at the Adelaide Hospital on June 26, 1890. Present: Dr. Cleland, President, in the chair; Professor Watson, Drs. Clindening, McIntosh, Perks, A. A. Hamilton, Hayward, J. A. G. Hamilton, T. K. Hamilton, Lendon, Leachen, Gregerson, Symons, and Lynch as Acting Secretary.

An apology was received from the Hon. Secretary, Dr. Poulton.

EXHIBITS.

DR. T. K. HAMILTON: (a) Operation for complete ptosis (right eye), with good result; (b) Two cases of concussion cataract.

PROFESSOR WATSON: (a) Carcinoma of supra-renal body.

ASSISTANT SECRETARY for DR. POULTON: Urinogenital apparatus of a male, 22 years, op. for nep. lithotomy. The opposite kidney was converted into a large multilocular cyst.

DR. T. K. HAMILTON proposed—"That the night of meeting be altered from the last Thursday in each month to the last Thursday but one."

DR. CLINDENING seconded.

DR. HAYWARD objected to such a radical change being discussed at such a small meeting. Members knew nothing about the motion till Dr. Hamilton proposed it, and he thought it should have been on the agenda paper.

The PRESIDENT overruled Dr. Hayward's objection, as Dr. Hamilton had formally tabled it.

Motion then put. *For*, 4; *against*, 4; casting vote of President, *for*. Carried; majority of 1.

ELECTION.

Dr. Altmann and Dr. Hamilton were unanimously elected.

Applications were received from Drs. Counter and Morris, but as their names were not on printed agenda paper the President ruled that according to by-laws they were not eligible for election at this meeting. To be ballotted for at next meeting.

THE ASSISTANT SECRETARY then read the Annual Report of Council and Treasurer's Report as follows:—

REPORT OF COUNCIL.

The Council has the honour to report that the numerical and financial position of your Branch of the British Medical Association continues to be satisfactory. Eight new members have been elected; three have retired. Death has removed one of our number in the person of the late Dr. A. W. Walls, of Mannum.

The roll now contains eighty-three (83) names, among whom for the first time we are glad to welcome graduates of the Adelaide University.

The Branch has held nine (9) meetings, and the following papers have been read:—

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| 1. Notes on Cases of Intestinal Obstruction .. | Dr. J. A. G. Hamilton |
| 2. A Case of Hæmatemesis Neonatorum .. | Dr. Hayward |
| 3. On Puerperal Temperatures .. | Dr. A. A. Hamilton |
| 4. On a case of Hydrocele with Milk-like Contents .. | Dr. Verco |
| 5. On a Case of Tumour of the Brain .. | Dr. Verco |
| 6. On a Case of Yellow Atrophy of the Liver .. | Dr. Hayward |
| 7. On Loreta's Operation .. | Dr. Gardner |
| 8. On Loreta's Operation .. | Dr. R. H. Marten |
| 9. On a Case of Spinal Injury .. | Dr. J. D. Thomas |

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| 10. On Cases of Hydatid Disease .. | Dr. J. D. Thomas |
| 11. On a Case of Knee-joint Disease .. | Dr. W. Anstey Giles |
| 12. On Extra-uterine Pregnancy .. | Dr. E. W. Way |
| 13. On Extra-uterine Pregnancy .. | Dr. Swift |
| 14. On Extra-uterine Pregnancy .. | Dr. Marten |
| 15. On a Case of Congenital Malformation of the Oesophagus .. | Dr. R. H. Marten |
| 16. On the Surgical Treatment of Hydatid Cysts of the Liver .. | Dr. B. Poulton |
| 17. On the Epidemic of Influenza .. | Dr. M. Jay |
| 18. On the Epidemic of Influenza .. | Dr. Verco |
| 19. On the Epidemic of Influenza .. | Dr. Bickle |

The Council think it would be to the advantage of the Branch if more attention were devoted to the production of papers dealing with subjects of the widest general interest, and to the discussion of everyday medical and surgical subjects. They note with regret the absence of contributions in therapeutics. The Council recommend that during next year a series of definite subjects should if possible be arranged as the principal matter for each monthly meeting, it being also provided that extra papers may be read on independent subjects. Whilst rather more papers were brought under your consideration in the past year than in that immediately preceding, the number of pathological exhibits has been less numerous, and perhaps less interesting. This is the more disappointing in view of the special provision made during the past year by an earlier hour of meeting, and especially as a closer attention to practical pathology is being given at the Adelaide Hospital.

By your instructions at the last annual meeting the publication of proceedings has been continued through the *Australasian Medical Gazette*, which will shortly supply to each member the collected transactions of the past year. The present agreement with the publisher of the *Gazette* terminates in September, and it will be for you to decide whether it shall be renewed.

The Council have been requested to alter the day of the monthly meetings. Any motion with this view may be brought before you to-night.

The receipts for the year amount to £193 17s. 11d.

The expenditure has been £155 5s. 10d.

There is to the credit of the Branch in the Savings Bank £155 14s. 3d.

BENJ. POULTON,
Hon. Sec.

June 26, 1890.

DR. HAYWARD moved, and DR. CLINDENING seconded, that they be adopted. Carried.

VOTING.—President: Dr. J. A. G. Hamilton; Vice President: Dr. Symons; Treasurer: Dr. Corbin; Secretary: Dr. Poulton; Council: Drs. Way, Cleland, T. K. Hamilton.

THE PRESIDENT, Dr. W. L. Cleland, Resident Medical Officer of the Parkside Lunatic Asylum, then read an address on "Lunacy Legislation" as follows:—

PRESIDENTIAL ADDRESS.

BEFORE retiring from the honourable position of President of the South Australian Branch of the British Medical Association, it behoves me, as following the example of my illustrious predecessors, to present you with a short address on some subject cognate to the special branch of medicine to which I devote myself. Seeing that the address emanates from the Parkside Lunatic Asylum, I trust you will not liken it to "a tale told by an idiot, full of sound and fury, signifying nothing."

The Report of the Council on the past year's work of the Society, together with the Balance-Sheet, will have told you all that is to be known respecting the present flourishing condition of the Society, so that I need not detain you by dwelling on that point, but I shall pass at once to the matter I have in hand.

The subject that I have chosen, namely, Lunacy Legislation, is a subject both of interest to the profession and to the public at large. As you are aware, the Lunacy Legislation of this Province is contained in two Acts of Parliament, dated respectively 1864 and 1865. It is not saying too much for these Acts to describe them as excellent pieces of legislation, and that they are simple and easily worked. They are fundamentally based on the English Lunacy Acts from 1845 to 1863. They are now a quarter of a century old, and it would be a curious anomaly if in this age of progress what was excellent twenty-five years ago is up to the requirements of to-day. As emphasizing this it may be mentioned that in England since that time there have been two additional Lunacy Acts of 1865 and 1885 respectively; and on May 1st, 1890, a third Act, called "The Lunacy Act Amendment Act," came into force. From this it is apparent that the Mother Country has not been idle in the matter of Lunacy Legislation. Our neighbour, Victoria, has also seen fit to bestir herself, and now rejoices in a "Lunacy Amendment Act, 1888," which came into force on January 1st, 1889. The previous Victorian Act was dated 1867. It is my intention to touch on a few of the more salient points of these amending Acts, and to briefly refer to one or two ideas which the reading of them has suggested.

One of the features of the English Act is the removal of the invidious distinction between the committal of private and non-paying or pauper patients. Both now in England can only be received into a lunatic asylum on the order of a magistrate. Formerly the order of a relative was sufficient in the case of a private patient, as it is here at the present time. This appears to me to be a step in the right direction, for on this point the procedure should be the same both for the rich and the poor. Another important innovation is that neither the rich nor the poor patient is to be subjected to the painful ordeal of an open court of justice. The magistrate receiving the application for an order of committal, whether from a relative or from a poor-law guardian, is equally bound to conduct the enquiry as quietly and privately as possible. This provision is also in the Victorian Act. I have always lamented that the law required for the committal of a patient having no private means that he be charged before a magistrate with being a "pauper lunatic," as though it were some crime or misdemeanour to be insane. And there is no doubt but that the patients feel this, for they frequently want to know what offence they have committed. The English Act appears to minimize the legal element to the narrowest limits, the magistrate simply acting as a representative of the commonwealth to see that everything is *bona fides* on the part of all concerned. For the proper protection of the personal liberty of the subject there must be some recognized supervision, and no more trustworthy class can be suggested than that of the magistrates. The Act further provides that only certain magistrates specially selected for the purpose shall exercise the power of granting committal orders to a lunatic asylum. A further new feature is the limited duration in time for such committal order to remain in force. First of all it is for a term of one year, then two, three and finally succeeding periods of five years. This, I think, is well as tending to cause a more healthy feeling in the public mind. Practically to

the patient I do not think that it will make any difference, as all the efforts of superintendents of lunatic asylums are rather to get their patients discharged than to allow an accumulation of chronics. As this, however, may not be generally known to the public, the provision in the new Act for periodical recommitments is upon the whole a healthy one. In the Victorian Act provision is made that the patients in the asylums be re-committed annually, the examining and recertifying medical man being one not connected with the Lunacy Department but appointed specially each time by the Government of the day. In my opinion this entails a needless expense on the community without any corresponding return, for it is well known that the prospects of recovery in an insane person greatly diminish as the years run on, and the symptoms of lunacy do not disappear. The idea is the same in both Acts. As regards the recapture of escaped patients in both the Victorian and English Amending Acts the period during which this may be effected is three months. This is an improvement on the Victorian Act of 1867 which made it "at any time." The New South Wales Act makes it 28 days, whereas according to the South Australian Act it is only 14 days. As the retaking of a patient is not an optional thing on the part of those concerned, but that the whole machinery of the police is set in motion to effect the same, it seems to me that the shorter time of the South Australian Act is much preferable. For it must be remembered that until the prescribed time has elapsed the unfortunate patient has to remain in concealment and to dodge the police officers as though he were a criminal. It is bad enough to have to do this for 14 days, but to have to do it for three months or even one month must be intolerable. As a matter of fact it is found in practice that if a patient can keep away a fortnight he is in a position to keep away altogether as regards that particular attack of insanity.

This matter of the escape of patients leads up to the idea as to whether all the patients require to be kept in a lunatic asylum. For some years now the Scotch Commissioners of Lunacy have been giving practical effect to the idea of boarding out lunatics with private families who are willing to undertake the charge. They report very favourably of the results. The system has not met with much favour elsewhere. Personally I do not take to the idea, for I have always been opposed to private individuals making a profit out of boarding, or as it may be called, the "farming," of the insane. This principle is carried to its extreme in some parts of Canada, where lunacy management is quite a century behind the times. Certain establishments there contract with the authorities to keep the patients at so much per head. The asylum in which recently the disastrous fire took place was one of these. The description, given by Dr. Hack Tuke of the management of this particular one, would have done for an asylum in the days before Connolly's great reformation. This extreme carrying out of the idea is naturally very far removed from any intentions of the Scotch Commissioners. The principle underlying it is, however, the same, and we should always remember the danger of adopting any system whose radical conception is unsound. Again, the experiences gathered from a contemplation of the working of the insane social community of the district of Gheel, in Belgium, which is nothing more than a huge boarding-out system, are far from reassuring. Notwithstanding this the Victorian Amending Act of 1888 makes provision for the carrying out of a similar experiment as advocated by the Scotch Commissioners. The English Amending Act treats the matter in a different and, I think, in a more satisfac-

tory way. Provision is made therein that the *relative* of any pauper patient may remove such patient, not being a dangerous one, and receive from the asylum funds a sum of money for the boarding of such insane relative as shall not exceed what it would have cost to keep such patient at the asylum. At the same time the connection between patient and asylum is not severed, and should occasion arise necessitating again the greater restraint of an asylum, the patient can be received back with as little trouble or fuss as though such patient had only been out for an airing. I feel sure that there are many chronics and weak-minded patients in our asylums who could be managed quite easily at the homes of their relatives. As these relatives are, however, persons without the means of keeping a non-producing member of the family, there is no alternative but to relinquish the control of their afflicted relative to the asylum authorities. In South Australia the weekly cost of a lunatic, including everything from the salaries of the officials downwards, is a trifle over eleven shillings per head. This does not include any interest on the cost of building, nor consequently on the sleeping and dining accommodation of the patient. Taking this into consideration it would pay the Government better to give a relative eleven shillings per week for looking after an insane but harmless member of his family, than to, as at present, congregate this class of patients in our ever increasing asylums. This I take it to be the view of the framers of the English Amending Act of 1889. Provision is further made that such boarded out patients, if at a distance from the asylum, shall be inspected at stated intervals by the poor-law medical officer, and reported upon by him, he receiving a fee for his trouble.

The Victorian Act contains a feature which is absent from the English Act, and which has evidently been borrowed from the New South Wales Act of 1879. It has reference to passing all fresh lunacy committals through a receiving house. The idea is that the patient may be "under observation" and thus lessen the chance of the scandal arising out of sending a sane person to a lunatic asylum. The term of detention at such receiving house is limited to twenty-eight days. If manifestly insane, the patient may be only detained two or three days before being sent on to the asylum. I fail to see the utility of this provision. If it is supposed that it will avoid the stigma which very erroneously attaches to the fact of becoming insane, I think that it must signally fail; for it must be as prejudicial to a person's mental reputation even to be suspected of being unstable, as to be formally committed as insane and then liberated a few days afterwards. Again, it is quite a needless precaution with such an Act as the present South Australian one, where provision is made for any doubtful case being at once examined by a competent board of enquiry. It is out of the question that any sober-minded person could be sent as a patient to the lunatic asylum, and if any individual chooses to be so erratic in his behaviour as to lay himself open to suspicion, he should be prepared to pay the penalty. He certainly should not expect the community to go to the expense of providing a sieve to ascertain whether he belongs to the all-square outsider, or more properly fits into the round mesh of insanity. And yet this is all that the Victorian Amending Act professes to do. The New South Wales Act is more sensible, for although the time of detention is put down as fourteen days, yet this may be prolonged apparently for any length of time required for the benefit of the patient. There is here some indication that the reception house may be availed of for treatment. Although many patients may recover within the month, as many

or more require three months, judging from the tables of the South Australian asylums. The Victorian Amending Act further provides that all doubtful cases shall be examined by the calling in, if necessary of a succession of outside physicians. The whole process is so cumbersome that one cannot be surprised that many of the alienists in Victoria look upon that portion of the Act with disfavour. A further point, as shewing that such reception houses are not required, is the fact that in every well appointed asylum there is such a numerous subdivision and consequent classification of the patients according to their mental condition, that a portion of any such asylum might easily be styled the reception division, to which all recent cases might be sent to be specially under observation. And if thought desirable further to emphasize the fact that it was only a reception division, the plan of procedure adopted in the South Australian asylums in the case of the transfer of criminal lunatics whose sentences have expired, to the pauper portion of the asylum, might be followed out with reference to transfers from the reception division to the other portions of the institution. This would be quite in keeping with the letter of the New South Wales Act respecting reception houses, for it speaks of "houses and premises, wards of any public hospital," and even portions of "any gaol" as being set apart by the Governor in Council for such purposes. Thus, instead of the tedious Victorian plan of procedure in the case of doubtful insanity, it would be much better for each asylum to have a small paid board of official visitors, who would meet weekly, interview the admissions since last meeting if not considered inadvisable from a medical point of view, and give the medical superintendent the benefit of consulting with them if he should so wish to do. The composition of such a board might contain a member of the legal profession, a member of the medical profession, and a layman, with the medical superintendent as chairman with a deliberative and a casting vote. I think the interests of the patients would be fully conserved by such an arrangement.

Whilst saying this much against the idea of reception houses as distinct institutions, I have long held the opinion that there should be "retreats" for those who are becoming insane but whose mental unsoundness could not be certified in such a manner as to satisfy the requirements of the present law. The first step would be the requisite legislation to oblige if necessary such a patient to enter a "retreat." As is well known, it is a very common peculiarity of mental disease that the sufferers from it are ignorant of the fact and indignantly repudiate the insinuation. In any other disease a patient seeks and is thankful for advice and treatment. If a patient with incipient signs of mental disease is to be treated he must in many cases be compulsorily treated. It is not necessary for me to dwell on the fact of how invaluable such early treatment would be both in the interests of the patient and the public at large. In no other disease is it more important to follow the advice of *proutipis obata*. I cannot conceive a more melancholy spectacle than to have to stand by as at present and watch a mind becoming day by day more unstable, until a time comes when the symptoms have become sufficiently pronounced to satisfy the law, when even a layman would in many cases have no difficulty in filling up a certificate of insanity. The legislation for the early treatment of mental unsoundness would necessarily be of a delicate nature, but it would be easy to surround it with the necessary safeguards both for the protection of the patient and the certifying physician. I may mention here that the English Amending Act makes provision for the protection of any persons concerned in the committal of an insane person against

vexatious civil or criminal proceedings, by directing that all such proceedings shall be stayed upon summary application to a judge, he being satisfied "that there is no reasonable ground for alleging want of good faith or reasonable care." The chief obstacle to the passing of the necessary legislative power would be the present exaggerated importance attached to the personal liberty of the subject. It is surely a travesty of this liberty to allow an unfortunate member of society to drift uncontrolled into what may become a living death, namely, the ultimate dementia of chronic insanity. How much better would it be if society were to stretch out its hand and endeavour to arrest the threatening mental suicide on the first step towards irresponsible action.

The character and surroundings and associations of such a retreat would be very different to that of any present lunatic asylum. It would be more on the plan of the every-day kind of accommodation of an ordinary household, and so arranged as to meet the pecuniary or impecuniary condition of the various inmates. There would be no necessity for the special requirements of a hospital for the insane, for should any of the inmates become acutely insane it would be best to place them in a lunatic asylum. It might profitably serve also another purpose, namely, a retreat for the inebriate. I am aware that South Australia has the proud distinction of having attempted to do something in this way, but I am afraid we must admit that circumstances have prevented the original conception from having that success which it deserved. There can be no doubt but that those who require to avail themselves of such a retreat are suffering from as decided a neurosis as any of the insane. As in the case of the incipient lunatic so with the habitual inebriate, both require in the great majority of cases to be treated compulsorily. At present if the alcoholic condition develops into a *mania-a-potu* the patient is sent to a lunatic asylum, and a residence there of from two to four weeks is generally sufficient for the effects of the poison to have worked off. The man is now sane, and if he insists upon it his discharge cannot be denied him. It is at this point that the defect of the present system comes in. The patient is sane, but he is still a victim to his alcoholic neurosis. Competent authorities inform us that compulsory abstinence from all alcoholic drinks for at least 12 months is the minimum time for hoping to effect any radical improvement. Again, the habitual drunkard is a most undesirable person to have in a lunatic asylum. Dr. Yellowlees, of the Gartnavel Asylum, Glasgow, speaks thus strongly on the matter:—"You cannot persuade them to remain long enough to get any real good, and I object to them for the sake of the other patients as well. I say you have no right to impose the company of such liars and mischief-makers upon respectable lunatics." Dr. Clouston, of Edinburgh, is equally opposed to their admission, "because he knew he could not do them the good that was necessary. He thought it was now time that something should be done in the matter." Legislation of a voluntary nature has been tried and proved utterly futile. According to the *Journal of Mental Sciences* for April, 1890, Mr. Morton, of Edinburgh, late Crown Agent, has prepared a bill to make provision for the care and treatment of those who, from morbid temperament or habits, have yielded to alcoholic or narcotic excess. Medical men of the standing of Professor Grainger Stewart, Professor Gairdner and Dr. John Duncan heartily support the movement, making compulsion the central idea of the proposed Bill. According to the Bill "if the patient refuses to apply voluntarily any member of his family, or any other near relative or a friend taking an interest in him, or a magistrate in

the public interest, may present an application to the sheriff to grant an order for reception and detention in a district or private home, the application to be accompanied by a statutory declaration by the applicant, and if the patient has such friends by a statutory declaration by two private friends who shall personally have seen him within seven days; also a certificate on soul and conscience by a registered medical practitioner who shall have seen patient within seven days. If the patient has no friends there must be two medical certificates. The application may be for reception into a home, and for detention for a period not exceeding twelve months."

The retreat which I have suggested might serve yet a third purpose, namely, as a convalescent home for those recovering from insanity. I have often wished that there was such a place entirely away from the asylum. We have, indeed, convalescent wards, but these naturally cannot exert the beneficial effect of an entire change of surroundings. Such a retreat would necessarily require to be under the complete control of a first-rate specialist in mental diseases, who would direct all things with a distinct view to the mental condition of his patients. A timely rest in such a retreat might often turn the balance in favour of a restoration to mental health. The present treatment of incipient insanity and allied neurotic conditions is about on as rational a basis as it would be if a surgeon were to take as an axiom that no inflammation should be treated until mortification or other tissue death had shown themselves. It says something for the robustness of the human mind when even under these disadvantageous circumstances the lunatic asylums can discharge a ratio of recoveries of from 50 to 60 per cent. on the admissions. I quote from the South Australian tables.

It might further be necessary that future members of the medical profession should be more fully taught than at present the value of the prodromic signs of mental disease. From my own experiences I can well recall how we students at Edinburgh were first stuffed with theory as full as we could hold by the late Professor Laycock, and then after that we went to Morningside Asylum where, having disgorged as much of this as we could, each one according to his mental robustness, we were given some excellent clinical instruction by Dr. Clouston, the Superintendent, on actual cases in the wards. There was nothing that I can remember on the diagnosis of the very earliest symptoms of mental alienation. And if we look at the examination papers for medical students where psychological medicine is taught, they to all intents and purposes resemble those set by the Psychological Association of Great Britain and Ireland for men who intend making lunacy a speciality. This appears to me to be fundamentally wrong. I do not mean to say by this that clinics at a lunatic asylum are of no use, for we have the testimony of Dr. Clouston to the fact "that students by score have told him that no part of their course was so interesting to them as the clinics of mental disease; that it seemed to take them into a larger field, to enlarge their sphere of vision, to look at things socially, at the conduct and motives from a medical point of view, which they had never done before." Although this may be very desirable still the general physician wants something more, namely, the much more difficult and in one sense more valuable knowledge of the earliest symptoms of approaching mental instability. He does not so much want to know lunacy in the way that the medical officer of an asylum knows it, because it is most improbable that he would be called upon to treat it at that stage of development. Our future

medical graduates cannot hope to acquire the knowledge which will be most useful to them unless some provision is made for clinically teaching it. The most feasible plan for effecting this that occurs to me is that it should form a part of the out-patient work at the Adelaide Hospital, say once a week, and that attendance thereat form a portion of the University teaching. The diseases might be called "neurotic diseases" so as not to frighten patients by suggesting the idea of insanity. The idea is not a new one of thus having an out-patient department for mental diseases, for I believe it has actually been put in practice by some of the leading asylums in Yorkshire. There was some little opposition to the idea on the ground that it might interfere with private practitioners. But as the proposed department as regards applicants would be exactly on the same footing as the other out-door patients, this obligation would not apply here. At the present time there is some agitation going on in London, set going by the Committee of the London County Council, as to the advisability of having hospitals for acute and recent insanity on the lines of a general hospital; that is to say with an honorary visiting medical staff, and specially devoted to clinical teaching. Dr. Clifford Allbutt, who was one of the witnesses examined, expressed an opinion adverse to the idea, and one that all superintendents of asylums will fully endorse. He says: "I found that opinion upon this consideration, the treatment of lunacy does not appear to me—I am open to correction—to be very much a matter of drugs or pharmaceuticals. I do not think that pharmacy will have a very large place in the treatment of the insane. That medicines may be of the utmost importance, and that they may be employed at times with the greatest possible advantage, no one of course would deny; but that they are usually of primary importance, or that they are the treatment of mental disease is, I think, not true. I think the true treatment is chiefly moral and humane, and not very much in the direction of drugs. I therefore think that the management of the place, the personal qualities of the medical superintendent, the personal qualities of every member of the medical and nursing staff is really the *cure*. The thing of cardinal importance is the intimate personal relation between the superintendent and his staff and the individual patient, the study of the patient's character and peculiarities, the ascertainment of his fears and delusions, his dreads, his suspicions, what are his hallucinations, and everything of that kind; and then the dealing with those mental conditions, as mind with mind. The superintendent is your medicine, the staff is your medicine, the nurses are your medicine, your conservatory and entertainments, your birds, your garden, and your farm are your medicines, and these things cannot be prescribed by visiting physicians."

I must now draw these remarks to a close, apologizing at the same time for having so long trespassed on your patience. My only excuse is that I think the subject is an important one, and one well deserving the attention of the profession and our public leaders.

The conclusions at which I arrive are:—

That recent lunacy legislation shows a distinct advance on some important points.

That the early period of insanity does not at present receive that attention which it merits.

That for this purpose legislation is required, together with an educating of the public mind up to its appreciation and the co-operation of the physician by emphasizing its importance by his advice.

That habitual drunkenness should be compulsorily treated as a form of insanity in retreats apart from lunatic asylums.

That there is presumptive evidence that psychological medicine is not at present taught on the lines most conducive to the practical education of the future physicians.

That it would be an educational and a public benefit if the poor could receive advice in any cases where the mind is becoming estranged or altered from the normal condition.

And that the idea of erecting lunatic asylums on the plan of a general hospital is unsuited to the requirements of the insane, and would be injurious to them.

He finally thanked members for the kindness and courtesy which rendered the honourable post of President to him a very great pleasure.

The President then vacated the chair, which was taken by the President Elect, who thanked members for the honour done by electing him. He regretted the lack of interest in members, and recommended more papers of everyday medical and surgical diseases should be brought before the Society. It was only in this way we could expect the affairs of the Society to interest country members. In conclusion he thanked Dr. Cleland for such an interesting paper on a subject to which such little attention was directed in our student days.

DR. MCINTOSH proposed a vote of thanks; he considered the paper a most valuable contribution.

DR. HAYWARD seconded, and referred to the deep interest and untiring energy in the Society which Dr. Cleland had shown since its inception. Carried by acclamation.

DR. CLELAND briefly replied, and the meeting then closed.

THE NORTH QUEENSLAND MEDICAL SOCIETY.

THE First Annual Meeting of the North Queensland Medical Society was held on Tuesday, June 17th, at the Town Hall, Townsville.

Present: Drs. D. Graham Browne, and Forbes, of Charters Towers; Clatworthy, Humphry, Nisbet, van Someren, Elliot, and Ahearne, President, of Townsville; Cuthbert, of Ravenswood.

In the absence of the President, DR. CUTHBERT proposed that DR. GRAHAM BROWNE, the Vice-President, take the chair. Seconded by DR. HUMPHRY.—Carried.

The minutes of the last quarterly meeting were read and confirmed.

The President having entered, he now took the chair. The Secretary (DR. G. A. VAN SOMEREN) then read his report, as follows:—

"Gentlemen,—It has been thought that it would be just as well to give a *resumé* of the steps which have been traced in the formation of the North Queensland Medical Society, by way of establishing a landmark on the occasion of this the first annual meeting of the Society; hence the reason of your patience being exercised with the following:

"The idea of such a Society seems to have been conceived in the minds of more than one of us, and the fermentation set going by the germs thus existent came to a head on Monday, December 9th, 1889, when a meeting of medical men in Townsville was held. The discussion of the subject at this meeting was so fruitful that it was decided to communicate with all the medical men in North Queensland, and invite their co-operation and interest. As a result of this decision about thirty medical men up to date have been applied to. There have been some difficulties in carrying out this decision, not the least of which was the fact that in consequence

of the as yet far from settled character of the country, few medical men consider themselves as fixtures, and frequent changes are taking place in different townships, so that some places are unrepresented. However, about twenty favourable replies were received, all couched in hearty and congratulatory terms, there being but one or two dissentients, whose names it may be as well to withhold, so as to give them an opportunity to retrace a course of action which we would fain hope they are now ready to retrace.

"The meeting of the 9th December, 1889, having been adjourned for a month, we again met on Monday, the 6th January, 1890, at which seven medical men were present, and as a result of the replies received the Society was unanimously formed. Dr. Ahearne took the chair, which had been taken at the first meeting by Dr. Frost. At this meeting nominations were put in for President, Vice-Presidents, Secretary, and Council, the constitution of the Society being broadly marked out.

"The minutes of this meeting were printed, and a copy of them, together with a voting paper, was forwarded to each acquiescent medical man in the North. Nearly all of these were returned—seventeen voting papers in all, and one more too late for being included in the scrutiny, but it would not have affected the result.

"A banking account has been opened with the Bank of North Queensland, to be operated on by the President and Secretary for the year. The balance in hand is £21 ls. 1d.

"The editor of the *Australasian Medical Gazette* was communicated with, and he kindly printed in the *Gazette* the minutes of the meeting of January 6th, 1890, and had a congratulatory leader upon the subject. He also offered to publish our proceedings and reports of our meetings. Such courtesy must be duly appreciated by each member, and it would be a delicate act on the part of the Society to respond suitably by taking in the *Gazette* and seeking to forward its interests.

"On the 31st-March, 1890, our first quarterly meeting was held, but, owing to the inclemency of the weather, the attendance was but meagre, there being only five present. The results of the voting were that the Council consists of Drs. Humphry, Clatworthy, and Nisbet, of Townsville, Paoli, of Charters Towers, and Hunt, of Hughenden. The President is Dr. Ahearne, Vice-Presidents, Dr. Graham Browne, of Charters Towers, who has taken a great interest in the Society, and has kindly assumed the burden of all arrangements in connection with the meetings in Charters Towers, and Dr. Spark, of Townsville. The Hon. Secretary and Treasurer is Dr. van Someren. At this meeting also a Sub-Committee was formed to draw up a draft of by-laws to be submitted for adoption to the annual meeting. This draft was forwarded to every member of the Society, and now remains to be discussed and adopted by you.

"On Monday, April 14, 1890, a meeting of the By-law Committee was held, when the draft was decided on, but held back to receive any suggestions our Charters Towers Vice-President might have to offer. Dr. Browne having no suggestions to make the final form of the draft of by-laws was adopted. A meeting of the Council was held on Thursday, 8th May, 1890, when the date of the annual meeting was fixed and notices ordered to be issued, and the order of the meeting arranged, and nominations for various other offices put in, and it remains for this meeting to duly elect those nominated or not as it sees fit.

"I have the pleasure to state that there are now twenty-one members in the society, in addition to which there are four others who have expressed their

intention of joining, but have not forwarded their subscriptions. There are many other medical men in the North who, I think, will join, if invited to do so, or when made aware of the existence of the society, as I propose they should be by forwarding to them a copy of the proceedings of the annual meeting and by-laws, if the Society so direct.

"Finally, gentlemen, I feel how gratifying it must be to all of us—for it has been due to the hearty co-operation and interest of all the members that we have got so far so well—to recognize that the Society has been successfully piloted across the sea of difficulties ever present in the career of such, and I trust a prosperous and influential future lies before us, having got safely through the throes of travail, the dangers of early infancy, and now about to face the ordeal of dentition. Adolescence and full manhood lie still ahead, and it is only by a due regard to details, and determination to present a united front to difficulties, that we can hope to have a triumphant career, and a respected and revered old age. The health of the whole organism is best subserved by a disinterested attention to the well-being and needs of each member. Hoping I have not wearied you by dwelling at such length upon our inception as a Society, I conclude, thanking you for your attention, and wishing every success to our Society."

Receipt and adoption moved by DR. CLATWORTHY, and seconded by DR. BROWNE. Carried.

Proposed by DR. ELLIOT—"That the hearty vote of thanks of the Society be awarded to the Secretary for being the instigator of the Society, tending to cement social and professional friendship." Seconded by DR. CUTHBERT. Carried.

By-laws considered.

Proposed by DR. NISBET—"That Rule 14 be amended as follows: 'quarterly' in place of 'monthly.'" Carried.

Proposed by DR. NISBET—"That Rule 16 be amended as follows: that after 'honorary' the words 'or corresponding' be introduced." Seconded by DR. BROWNE. Carried.

Proposed by DR. BROWNE—"That in Rule 20, before the words '8 p.m.' 'or at such other date as the Council may decide' be added." Seconded by DR. CLATWORTHY. Carried.

Proposed by DR. FORBES—"That Rule 21 be struck out." Seconded by DR. ELLIOT. Carried.

Proposed by DR. ELLIOT, and seconded by DR. CLATWORTHY—"That Rules 22 to 30 inclusive be adopted." Carried.

Auditors, Trustees, and Curator, as nominated, were elected.

The PRESIDENT now read his address.

DR. ELLIOT proposed a hearty vote of thanks to the President for his able address, and that it be received and printed, as our recognition of the research shewn in preparing same.

DR. BROWNE, on rising to second Dr. Elliot's vote of thanks for the valuable paper read by the President, said that it was unnecessary for him to say anything with regard to the introductory portion of the paper as to the benefit of such a society as the North Queensland Medical Society, but simply to endorse the President's statements. With regard to some of the questions mooted, he held that while anæmia in Australia may exist in early childhood, and in the female sex during the early years of menstruation, yet that later on, probably owing to the plentiful diet, after puberty strength and endurance were unusually developed, as shewn by the superiority of Australians in all sports demanding strength and endurance. In speaking of

cholera, Dr. Browne begged to point out how much the spread of cholera was influenced by the purity of the water supply, as evidenced by the comparative numbers before and after a pure water supply in cholera epidemics in Vienna and elsewhere. Dr. Browne fully endorsed the remarks on the necessity of legislation as to compulsory vaccination, and agreed that sanitary reform was only to be obtained by educating the masses, especially the rising generation. He hoped also to see Queensland become a nation of claret drinkers, and that the doctored ales and spirits would be replaced by light wines.

MEDICAL SOCIETY OF QUEENSLAND.

The Forty-first General Meeting was held in the School of Arts, Brisbane, on April 8th, at 8.30 p.m.

Present : Drs. W. S. Byrne, Owens, Bindon, P. Bancroft, Thomson, Little, Hill, Taylor, Hardie, Lyons, Booth, Quinell, and Love. Visitor, Dr. Griffin.

DR. LOVE shewed a large fibro-cystic tumour of the uterus, weighing 27 pounds, which he had removed several days before.

The minutes of last meeting were read and confirmed.

DR. BOOTH then brought forward his motion "That the Council be requested to draw up a scale of fees for the guidance of members." Seconded by Dr. P. Bancroft. Carried.

DR. LITTLE gave notice that he would move at the next meeting "That a deputation wait upon the Minister for Justice to urge upon him the necessity for better remuneration for medical men doing government work."

DR. OWENS read notes of two cases of "Atropine Poisoning." The Secretary read for Dr. Robert Thompson notes of a similar case.

DR. BYRNE read his paper on "Fevers of the Puerperal State," which will appear in our next issue. Considerable discussion followed, in which Drs. Taylor, Little, Thomson, Hill, and Love joined.

The Forty-second General Meeting was held in the School of Arts, on June, 10th, at 8.30 p.m.

Present : Drs. Byrne, Thomson, Taylor, Little, Hill, Hardie, P. Bancroft, Connolly, and Love. Visitor, Dr. H. A. Francis.

The minutes of last meeting were read and confirmed.

DR. LOVE shewed a piece of ileum in which an intussusception had taken place. Laparotomy had been performed unsuccessfully, the invaginated gut being firmly glued to the intussusciptions. Obstruction had existed for five days, and the patient was very collapsed before she was admitted to the hospital.

DR. LITTLE then brought forward his motion "That a deputation wait upon the Minister for Justice to advocate better remuneration for medical men doing government work." He pointed out that the fees allowed for long distances were quite inadequate, being only at the rate of 1s. per mile. Seconded by Dr. Taylor.

DR. THOMSON moved as an amendment "That a deputation from this Society wait upon the Minister for Justice and other members of the Cabinet, after having drafted an amended Medical Bill which will correct the defaults of the present Act chiefly with reference to registration, to the prosecution of irregular practitioners, and to a scale of fees." Seconded by Dr. Hill. Carried. Drs. Thomson, Hill, and Owens were appointed a committee to amend the Medical Act and submit it to a special meeting of the Society to be held on June 26.

THE SECRETARY reported that the Council advised the purchase of Hutchinson's "Illustrations of Clinical

Surgery," and that the Society should subscribe to the new Sydenham Society. Agreed.

THE HON. TREASURER was empowered to order these works, the Sydenham Society's subscription to date back four years, whereby the Society would get an extra guinea's worth of books.

THE PRESIDENT intimated that the Council had considered the recommendation of the general meeting of April 8 to draw up a scale of fees for the guidance of members, and had decided to advise the adoption of the New South Wales scale as printed in the last edition of "Bruck's Australasian Medical Directory."

THE SECRETARY read the list of fees over, but the discussion was postponed to a future date. A microscopic demonstration was then given, some good slides of actinomycetes, among other things, being exhibited from cattle killed locally.

THE WESTERN MEDICAL ASSOCIATION OF SYDNEY.

THE members of the Association were entertained at dinner by the council on Tuesday evening, June 10th, at Roberts' Hotel, Sydney.

Thirty-one members of the Association were present, and apologies were received from fourteen who were unable to attend. Professor Anderson Stuart, President of the Medical Section of the Royal Society, The Hon. Dr. Creed, Editor of *The Australasian Medical Gazette*, Dr. Worrall, Hon. Sec. New South Wales Branch of the British Medical Association, were also present. Apologies for non-attendance were received from Dr. Manning, Government Medical Adviser, Dr. Hankins, President New South Wales Branch of the British Medical Association, and Drs. Hull and McAllister, Hon. Secs. of the Medical Section of the Royal Society.

After dinner the toast of "The Queen" was proposed by the President, Dr. MacSwiney, and duly honoured. "The Western Medical Association" was proposed by The Hon. Dr. Creed, who dwelt on the needs and advantages of such societies. The toast was responded to by Dr. Collingwood, who explained the aims and objects of the Association, and that it was not in any way antagonistic to the societies already in existence. He stated that this was the first association formed in Australia on defensive lines, and shewed the necessity of stopping the oppressive action of the different Friendly Societies.

"Kindred Societies" was proposed by Dr. P. Sydney Jones in a very able speech and responded to by Professor Anderson Stuart, who referred to the vast improvement in the working classes wrought by the agency of trades unions, and considered that much good could be wrought by a somewhat similar organization amongst medical men. He stated that he considered the province of the Medical section of the Royal Society to be purely scientific work, the more strictly medical work being left to such societies as the British Medical Association and this Western Medical Society.

"The Public Medical Service" was proposed by Dr. Hurst, who paid a great compliment to the medical men in the government service of New South Wales. Dr. Woodward replied to the toast in appropriate terms. The toast of "The Ladies" was proposed by Dr. Moir and responded to by Dr. Fitzpatrick and Dr. Clune. The toasts of "The Council" and "The Secretary" brought a very pleasant evening to a conclusion.

During the evening a party of five gentlemen, who were present by invitation, sang several pieces very effectively, and considerably increased the enjoyment of those present.

Dr. Houson, the Secretary of the New South Wales Medical Board has, at the request of the Council, kindly consented to hand a copy of the rules and by-laws of the Association to each applicant for registration.

The following gentlemen have been elected members :—Drs. Little, Deck, Ashwell, Munro, P. M. Wood and A. K. Cox.

The following have been elected honorary members :—Drs. Clay, Long, Lyden, Macky, McAllister, MacKellar, McMurray, Marshall, Morton, Muskett and C. Wilson.

A circular relating to two lodges in the Glebe has been issued :—

"Petersham, 25th June, 1890.

"Dear Sir,—I beg to bring under your notice the fact that the following lodges have become vacant through a member of the Western Medical Association, residing in the Glebe, desiring to raise the fees for attendance on the members of the lodges to the standard adopted by the Association. The names of the lodges are :—Boyne Lodge, P.A.F.S.; Glebe Union Lodge, G.U.O.O.F.

"According to a rule of the Association no member will oppose the re-election of the medical man now holding these lodges.

"Your attention is directed to the fact that the New South Wales Branch of the British Medical Association have by resolution requested the members of the Branch not to tender in the districts embraced by the Association under the minimum limit, and the Council of the Western Medical Association appeal to you as a member of an honourable profession to support the medical man who has resigned his lodges to maintain a principle acknowledged by the whole profession to be just and fair.

"I remain,

"Yours obediently,

"W. H. COUTIE, Hon. Sec."

The following letter has been issued on the authority of the Council :—

"Parramatta, 27th June, 1890.

"To the Secretary, Parramatta Friendly Societies' Medical Institute,

"Dear Sir,—We, the undersigned medical practitioners residing in Parramatta, being members of the Western Medical Association, beg to inform the members of the Parramatta Friendly Societies' Medical Institute through you that in consequence of the rules of the above Association we shall not be able to meet the medical officers of your Institute in consultation until the salaries paid to those gentleman be raised to the minimum scale fixed by the Association, viz. : £1 per member for ordinary lodges, and 15s. per member for female lodges per annum, exclusive of medicine, this notice to take effect from July 31 next. We also beg to state that our Association will inform any candidate who may apply for the position of medical officer to your Institute (until the salaries are raised to the rates named above) of the position they will occupy in the town, unrecognized by their professional brethren here or in Sydney, and unable to obtain their assistance in a case of doubt or emergency. In order that all the members of the various lodges forming your Institute may be aware of the position they will be placed in, a copy of this letter will be sent to the secretary of each lodge.

"We remain, yours faithfully,

"(Signed) WALTER BROWN, M.D.

J. WAUGH, M.B.

C. JOHNSON, M.D.

G. H. PHILLIPS, M.R.C.S.

REGINALD BOWMAN, M.B.

W. SIGISMUND BROWN, M.R.C.S."

PROCEEDINGS OF COLONIAL MEDICAL BOARDS.

The following gentlemen, having presented their diplomas, have been duly registered as legally qualified Medical Practitioners by the respective Boards :—

NEW SOUTH WALES.

Wood, Percy Moore, L.R.C.P. Lond. 1879; M.R.C.S. Eng. 1878.
Bury, Herbert Taylor, L.R.C.P. Lond. 1885; M.R.C.S. Eng. 1884.
Stevenson, Bernard, L.R.C.P. Edin. 1884; L.R.C.S. Edin. 1884.
Cox, Allister Edward, M.B. & M.S. Univ. Edin. 1888.
Cribb, Arthur William Gordon, L.R.C.P. Lond., 1889; M.R.C.S. Eng. 1890.
Row, Linford Elia, L.R.C.P. Edin., 1889; L.F.P.S. Glasg., 1889; L.R.C.S. Edin., 1889.
Baber, John James Yarrow, L.S.A. Lond., 1882; M.R.C.S. Eng. 1882.
Kirkland, Thomas Spiers, M.B., M.S. Univ. Glasg., 1887.

For additional Registration :—

Townley, Percy Langford, M.Ch. Univ. Sydney, 1890.
Davidson, Lealie Gordon, M.Ch. Univ. Sydney, 1888.

NEW ZEALAND.

Rowand, Andrew, M.B. & Ch. M. Edin. 1887.
Saunders, George Richard, M.B. & Ch. B. Camb., L.R.C.P. Lond., M.R.C.S. Eng.

QUEENSLAND.

Dobbin, William Sinclair, M.B. & Ch. B. Dubl. 1886; F.R.C.S. Irel. 1886.
Gledden, Alfred Maitland, L.R.C.P. Lond., M.R.C.S. Eng. 1884.
Mackenzie, Arthur Colin, L.R.C.P. & R.C.S. Edin. 1886; L. & L. Mid. F.P.S. Glasg. 1886.
Francis, Henry Alexander.

SOUTH AUSTRALIA.

Counter, Francis William, M.B. & Ch. M. Aberd.
Leschen, Henry Adolf, M.B. & Ch. M. Edin.
Goldsmith, Frederick, M.B. & Ch. B. Adel. 1889.
Gregerson, William Jens, M.B. Melb. 1889.
Coombe, E. B. S., M.B. Durh. 1889; L.S.A. Lond. 1887.
Perks, Robert Howell, M.D. Brux. 1883; M. 1881, F. 1884, R.O.S. Eng.; L.R.C.P. Lond. 1882.
Hamilton, Reginald H., L.R.C.S. Irel. 1889; L. & L. Mid. K.Q.C.P. Irel. 1889.
Lynch, Arthur Francis Augustine, M.B. & Ch. B. Adel. 1889.
Michie, John, M.B. & Ch. B. Melb. 1890.
Ternan, Percival John Whitfield, L.R.C.S. Irel.; L.K.Q.C.P. Irel. 1886.
Leitch, J. W.
Stewart, H. G.
Stewart, J. A.

TASMANIA.

Neale, Alfred James, M.B. & Ch. M. 1883, M.D. 1886 Edin.
Sprott, Gregory, M.B. & Ch. M. Glasg. 1885.

VICTORIA.

Day, Frederick Arthur, M.B. & Ch. M. Edin. 1889.
Naylor, Henry George Horace, L. & L. Mid. R.C.P. & R.C.S. Edin. 1874.
Moore, George Ogle, M.R.C.S. Eng. 1890; L. & L. Mid. R.C.P. & R.C.S. Edin. 1888; L.F.P.S. Glasg. 1888.
Crooks, Alfred Watson, L. & L. Mid. R.C.P. & R.C.S. Edin. 1890; L.F.P.S. Glasg. 1890.
Outhbert, John, L.R.C.S. Irel. 1886; L.R.C.P. Edin. 1886; L. Mid. K.Q.C.P. Irel. 1886.
Bruehl, Siegwart, M.D. Halle, 1891; Staats Exam. 1883.
Long, John Peter, L.R.O.S. Irel. 1888; L.A.H. Dubl. 1888.
Sloggett, Harry Paynter, L. & L. Mid. 1887; Dip. State Med. 1889; K.Q.C.P. Irel.; M.R.C.S. Eng. 1890.
Daly, Charles Andrew, L.R.C.S. Irel. 1883; L. & L. Mid. K.Q.C.P. Irel. 1883.
Strangman, Cecil Lucius, L. & L. Mid. R.C.P. & R.C.S. Edin. L.F.P.S. Glasg. 1888.
Diamond, William, M.B. & Ch. M. Glas. 1888.
Mitchell, James Thomas, M.D. & Ch. M. Aberd., M.R.C.S. Eng. 1879.
Kelly, James Patrick, L. & L. Mid. R.C.P. & R.C.S. Edin., L.F.P.S. Glasg. 1889.

Additional Qualifications Registered :—

Wood, W. Atkinson, Ch. B. Melb. 1888.
Bennie, A. Bruce, Ch. B. Melb. 1889.

NOTICE.

The Editor will feel obliged by any gentleman, who wishes to ventilate any subject of professional or public interest, writing an editorial or leading article on it, which if found on perusal to be consonant with the policy of the paper, will be inserted in an early number.

All communications intended for the Editor should be sent to the 'A. M. Gazette' Office, 35 Castlereagh Street, Sydney.

*** Contributors can have their Papers reprinted and published in Pamphlet form, at Cost Price, if the necessary instructions are given to the Publisher at the same time the contributions are sent in.*

AUSTRALASIAN MEDICAL GAZETTE.

SYDNEY, JULY 15, 1890.

EDITORIALS.

THE ADMISSION OF LUNATICS TO NEW SOUTH WALES.

We reprint the following very important paragraph in the annual report of Dr. Norton Manning, as Inspector-General of the Insane, because we believe absence of a similar law relating to the admission of insane persons to those which exist in the rest of the Australasian Colonies is a cause of serious cost and imposition on the taxpayers of New South Wales.

"In former reports I have called attention to the number of patients admitted either direct from the ship or soon after their arrival in the colony. During the year 1889, 29 patients were so admitted, and of these six were brought direct from the ship to hospital. Two of these cases were known to be booked for Melbourne, but were brought on to Sydney because, had they been landed in Victoria, the owners or agents of the ship would have been liable for their maintenance to the Victorian Government, under the provisions of a special Act forbidding the importation of insane, infirm, and incapable people. Acts containing similar provisions are in force in South Australia, Queensland, Tasmania, and New Zealand; and every year persons who should be landed in other colonies are brought on to New South Wales and become chargeable to the Government.

"Similar action will no doubt continue to be taken so long as this colony admits without inquiry or remonstrance every person who may be brought here; and it certainly seems advisable that an Act to prevent the importation of

incapable people should be passed, so as to put New South Wales on the same footing as the other colonies in this particular. There would, I believe, be no difficulty in showing that an expenditure of between £5,000 and £6,000 a year is incurred by the maintenance of insane persons who are not properly chargeable to this colony."

No one after reading the above can doubt that it is the immediate duty of the Government to pass such an Act of Parliament as will neutralize the evil.

A NEW MEDICAL BILL FOR NEW SOUTH WALES.

A BILL of this kind has been read a first time in the Legislative Council of New South Wales, on the motion of the Hon. Dr. Bowker. Some of the provisions would, if it became law, be an improvement on the state of things which now exist, but others of its provisions in no way meet the situation, and would but tend to perpetuate evils now going on. As in our opinion the introduction of such a Bill by any private member places it beyond the range of practical politics we do not think we are justified in devoting more of our valuable space to its more detailed criticism. We think the introduction of this Bill by the honourable member the more inopportune as notice has been given by Mr. Ewing of a resolution to be moved in the Legislative Assembly this evening, with the object of pressing upon the Government the necessity of a proper Bill for the protection of the public being introduced as a Government measure.

THE WESTERN MEDICAL ASSOCIATION OF SYDNEY.

By the proceedings published in another column it will be seen that the Western Medical Association is active in its mission, and is taking worthy and efficient measures for raising the status of the medical officers of Benefit Societies. This society, while not losing sight of matters of interest in relation to clinical work, is taking up others which the older societies have found somewhat out of their range; and though acting in the immediate interest of medical men in their own or surrounding neighbourhoods, are yet doing much good in that of practitioners in all parts of Australia. We are pleased to hear that the preliminary steps are being taken to form a society on

similar lines in Brisbane. We would point out to all medical men thinking of applying for appointment to any lodge that before doing so it will be greatly to their interest to communicate with the active courteous secretary of the Association, Dr. Coutie, Petersham, Sydney. They will find that through the action of the Society the position of the medical officers has been much improved, and that the remuneration has been raised to something approaching a fair rate of pay.

LETTERS TO THE EDITOR.

DR. MUELLER'S CASE OF ACUTE ATROPHY OF LIVER.

(To the Editor of the A. M. Gazette.)

SIR,—I have neither the time nor the will to enter into any controversy with one so qualified to write as Dr. Mueller regarding his case of acute atrophy of the liver, but I do not think that the somewhat unusual statements he makes should pass unnoticed. Having read his series of papers on snake poisoning with no little interest, I began reading the article in question, in the hope, at least, of having the matter treated in a scientific spirit, but confess to have been disappointed.

It gave me some surprise, that one who claims to be a scientist, and who belongs to a scientific profession, should give the pathology of a case on the strength of mere symptoms, in which, fortunately or unfortunately, there was no chance of having a *post mortem* examination, and who perhaps has never even handled nor examined with the naked eye a liver in a state of acute atrophy. Not only so, but he finds himself in a position to criticize some of our greatest authorities, who, perhaps, see more cases of liver disease in a week than he does in a year.

But what can be the value of Dr. Mueller's idea of the pathology of this disease, when he does not seem to me to know even the microscopical anatomy of the liver. He speaks of the hepatic cells as if they were mere vesicles, such as you find in the lung or other spongy tissue. If he does not know, he ought to know before attempting anything in the way of pathology, that the individual cells have no surrounding connective tissue, and that, as far as we know at present, the bile capillaries do not commence in the cells, but originate as mere minute channels, with perhaps delicate living membranes of their own *between* them. Suppose, however, for the sake of argument, that his anatomy of the liver, and its pathology in a condition of acute atrophy is correct, what would we expect to find during life and after death? Certainly not an atrophied liver! I, at any rate, would look for two things—an enlarged and engorged liver, and at the *post mortem* would expect it to be stained, not of a yellow colour, but of the colour of this dark putrid bile with which it is permeated, and which Dr. Mueller looks on as the cause of acute yellow atrophy. Now, if his theory is correct, in the first place the disease I fear would be a very common one, for we can hardly give him credit of being one of a few who can successfully remove inspissated

bile by means of cholagogues, and in the second, how does he account for those cases of acute atrophy where the patient does not once during all the illness either vomit or pass dark feculent matter, and where no trace of such dark material can be detected after death, either in the liver or intestine? The primary question here arises: Is it true or is it not true that the dark matter in this case was really putrid bile? Dr. Mueller confesses that he had "neither the means nor the time to make an analysis that alone would settle this matter." He merely "feels confident" that it was so, but the tests applied were so meagre that he can hardly be surprised if he does not impart the same feeling of confidence to others. It is looked on by our great men as merely decomposed blood, and until he can finally and conclusively prove the contrary it is worse than useless giving us the pathology of this very interesting case.

Having gone so fully into the *rationale* of this disease, as far as the liver goes, why does he stop short and not give us the benefit of his ideas, regarding the changes that are going on at the same time in other important organs, the spleen and the kidneys; for we now know that these organs undergo changes not less remarkable than the liver?

But the question arises, was Dr. Mueller's case a bona fide one of acute yellow atrophy of the liver? Let us see on what his diagnosis rests. He says:—"The early delirium combined with subnormal temperature, the pain in the right hypochondrium, the reduced area of hepatic dulness, the spleen enlargement, and the extreme feebleness of the heart's action were both *singly* (the italics are mine) and collectively thoroughly pathognostic symptoms admitting of but one interpretation."

1. The early delirium. I should say the delirium was too early. The boy was in good health without any sign of jaundice, I presume (for this point is not mentioned) at the most, twenty-four hours previous to the onset of delirium. This early delirium is at best a very unusual symptom, and I would look on it as a fairly certain proof that it was due to something even more active than an atrophied disorganized liver.

2. Subnormal temperature. It is acknowledged that when delirium sets in there is generally (invariably in my cases) a rise of from two to four degrees of temperature.

3. Pain in the right hypochondrium. Do we not also find pain in this situation from other causes, such as the passing of a gall stone, or inspissated bile, or the presence of some irritant in the duodenum?

4. Reduced area of hepatic dulness. It would be interesting to know what is Dr. Mueller's estimate of the area of hepatic dulness in a healthy boy eleven years of age. One having a vertical dulness of nearly two inches is quite large enough for boys of this age that have come under my observation, and yet no one would imagine it was atrophied. As far as the tympanic note over the left lobe is concerned, I am not aware that this is an unusual symptom, for we all know how the colon distended with gas frequently covers the normal left liver dulness.

5. Spleen enlargement. I confess that in this respect my experience does not coincide with writers generally on this disease. I have invariably found the spleen in an atrophied condition, so much so that "the disease might as correctly be designated acute atrophy of the spleen." In this case the enlargement must have been very marked, for the diameter of the organ was increased nearly two inches, or in other words, for a boy of this age, it had almost doubled itself in less than twenty-four hours.

6. Extreme feebleness of the heart's action. So also is the pulse feeble under the influence of some toxic poison pure and simple. Indeed it is more characteristic of this than of acute atrophy, for in the latter disease, unless when deeply comatosed, the pulse is fairly full and strong.

Three other matters require notice :—

7. The degree of jaundice. Dr. Mueller says, the motions at first "were almost devoid of bile colouring," the urine contained a "large quantity of bile," and the skin was "decidedly yellow." This is exactly the opposite of what we find in acute atrophy, at least in very acute cases, in which there is in the urine but a faint colouring of bile, while the motions contain a fair amount of bile, and even after death there is generally in the intestines a certain amount of feculent matter distinctly bilious in character.

8. The presence of leucin and tyrosin in the urine. This is really the only sign mentioned diagnostic of acute atrophy. But we must bear in mind that they are not generally, if ever, observed in acute atrophy in the very early stage, and at the same time that they are found in the urine in other distinct diseases, such as typhus fever and variola, and in phosphorous poisoning. Whether in the two former the liver is in a condition of acute atrophy I do not know. In phosphorous poisoning the liver is sometimes atrophied and sometimes hypertrophied.

9. Age of patient. Acute yellow atrophy is very rare in children—so rare that Frerichs, Niemeyer and Trouseau have never seen a case.

No one can read Dr. Mueller's paper without expressing admiration for the treatment of his case, and he is to be congratulated on its successful termination. Had it been one of genuine acute atrophy with the disorganized condition of the liver, spleen and kidneys that is found in these cases I would certainly not have expected such a favourable result. It is a pity he was not less dogmatic in his diagnosis, and did not leave the pathology alone till he had had more experience of the disease, for the correctness of the former is very doubtful, while the latter is merely assumptive and therefore unscientific.

I am, Sir,

Yours faithfully,

DAVID HARDIE, M.D.

Brisbane, 9th July, 1890.

A QUESTION OF MILEAGE.

(To the Editor of the A. M. Gazette.)

SIR,—Will you kindly inform me as to what is right under the following circumstances?

I am ten miles away from home, at a patient's, where I intend staying all night. At about 10 p.m. a message comes requiring me back at "head-quarters." I attend to it immediately. Am I justified in charging mileage for the ten miles travelled that night?

I am, sir, yours truly,

TAS.

[This is a difficult case to decide, for it seems a little out of the ordinary way for a medical man to charge mileage back to his own house. Our correspondent, no doubt, made a special journey at night for the benefit of his patient, and therefore his demand is not an unfair one; but we think it would have been better had he notified to the messenger that he intended to charge mileage as for an ordinary journey if he returned specially to attend to the case.—ED. A.M.G.]

REGISTERED AND UNREGISTERED PRACTITIONERS.

(To the Editor of the A. M. Gazette.)

DEAR SIR,—You will find enclosed an advertisement cut out of the last number (issued June 27, 1890) of the *Richmond River Express*, wherein Dr. Parker, a legally-qualified medical man, notifies the public that he has taken charge of the practice of an *unqualified* * practitioner during his temporary absence.

Now I and several other medical men in this district will be glad if you will kindly give us your authoritative opinion as to whether such conduct is *professional* or conducive to that high standard of equity and self-respect that all medical men should regard as sacred.

I may mention that there was lately a question as to a possible *partnership* between these two gentlemen! (a qualified and unqualified * man), and that the qualified gentleman has constantly during the last two years met the unqualified * man in consultation and *even assisted him in operations!*

Can we wonder after this at the low estimate in which the profession is very generally held in New South Wales?

I am, dear Sir,

Your faithful servant,

EUSTACE H. C. PRATT, M.R.C.S. ENG., &c.
Lismore (Richmond River),

July 2, 1890.

[We are pleased to know by the above letter that so satisfactory a change has arisen in the opinions of Dr. Pratt on this very important subject. His present attitude towards unregistered medical practitioners is in such extremely marked contrast to that he took up with regard to them some six years ago, as shown by a communication from him published in the *A.M. Gazette* for April, 1884, on page 157 of vol. iii., which said: "When I find a good conscientious man, with fair knowledge, practising medicine in the bush, I am always willing to meet him, be he legally qualified or not," that we feel it but our duty to tender him our very sincere congratulations on the highly proper attitude he has now assumed.—ED. A.M.G.]

* *i.e.*, without diploma and unregistered.—ED. A.M.G.

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- EUSTACE SMITH, DISEASES IN CHILDREN, 2nd ed., 1889, 22s.
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&c., &c., &c.

Postage extra, at the rate of 1s. 6d. to the £ of order.

THE MONTH.

NEW SOUTH WALES.

THE New South Wales Branch of the British Medical Association, at a well-attended meeting held on the 6th June, passed a resolution affirming the desirability of completing the erection of the Sydney Hospital, and appointed a deputation to bring the matter under the notice of the Government. Great stress was laid by the speakers in support of the resolutions on the present insufficiency of hospital accommodation, and the dangerous and unsatisfactory condition of the temporary buildings now in use for hospital purposes on the site of the proposed Sydney Hospital.

THE HON. DR. BOWKER brought in a bill in the Legislative Council on June 27 to regulate the practice of medicine and surgery in the colony of New South Wales, and it was read the first time.

A CHINAMAN who applied for admission to the Deniliquin Hospital on July 3 was found to be suffering from leprosy.

MR. BERNARD STEVENSON, L. & L. Mid. R.C.P. & R.C.S. Edin. 1884, formerly of Healesville (Vic.), and late of Hillgrove, died at Gosford on June 18, at the early age of 28, from the effects of an overdose of morphia, self-administered; the deceased was a native of Nottingham (Eng.), and arrived in Australia four years ago.

DR. J. W. HART has been elected one of the Medical Officers of the Parramatta Friendly Societies' Dispensary, in the place of Dr. Trindall, who, as a member of the Western Medical Association, resigned the position owing to the salary paid not coming up to the minimum scale fixed by the Association.

DR. T. E. ATKINS has removed from Balranald for Ivanhoe, 734 miles S.W. of Sydney. Previous to his departure from Balranald he was presented with an illuminated address and a handsome liquor stand.

DR. W. CAMAC has commenced practice at Hill End, 205 miles N.W. of Sydney; he has been appointed Surgeon of the local hospital.

DR. ALLASTON COX has succeeded to the practice of Dr. A. L. Heale at Strathfield, a suburb of Sydney.

DR. J. P. KEALY, late of the Gulgong Hospital, and formerly of Charters Towers (Qu.), has been elected one of the two Medical Officers of the United Friendly Societies in Newcastle in the place of Dr. Ward, who intends going home.

DR. THOS. S. KIRKLAND, a new arrival, has commenced practice at Blayney, 196 miles W. of Sydney.

DR. C. W. MORGAN, J.P., who is about to leave Newcastle for Wagga Wagga, was entertained at dinner at the Great Northern Hotel, on July 11, by a number of citizens. Mr. Alex. Brown, M.L.A., presided, and the vice-chair was filled by Mr. Joseph Wood, J.P. The gathering was of a large and representative character. His departure is generally regretted.

DR. L. PRAAGST, late of the Women's and Melbourne Hospitals, has settled at Balranald, 554 miles S.W. of Sydney. Dr. Praagst has been appointed Medical Officer of the local hospital.

DR. W. E. STRONG, late Government Medical Officer in Sydney, has settled at Bodalla, 212 miles S.W. of Sydney.

DR. G. WATT, formerly of Cobar, has removed to Hay, the centre of a large pastoral district, 454 miles S.W. of Sydney.

DR. FRED. WILLIAMS, formerly of Blinman (S.A.), has settled at Balranald, 554 miles S.W. of Sydney.

DR. P. M. WOOD, formerly Government Medical Officer at Port Darwin (N.T.), has succeeded to the practice of Dr. L. Fitz Patrick at Holden-street, Ashfield, a fashionable suburb of Sydney.

NEW ZEALAND.

DR. ANDREW ROWAND has been appointed Medical Superintendent of the lunatic asylums at Wellington and Porirua.

DR. J. HENRY, of Wellington, has been appointed Certifying Officer for the Vaccination Districts of Wellington, Featherstonhaugh, Greytown, Masterton, Castlepoint, Carterton, and Otaki, *vice* A. Johnston, M.D., resigned.

DR. G. R. SAUNDERS has commenced practice at Wanganni, 144 miles N. of Wellington.

DR. JAMES TILBY, who left Pukekohe for Barotonga in the South Sea, a few months ago, has returned to New Zealand, as the climate does not appear to have agreed with him.

QUEENSLAND.

THE first annual meeting of the Medical Society of North Queensland was held at Townsville on June 17. The president, Dr. Ahearne, gave a suitable address, and there were also present Drs. Graham Browne, and Forbes, of Charters Towers; Dr. Cuthbert, of Ravenswood; and Drs. Clatworthy, Elliot, Humphry, Nisbet, and van Someren, of Townsville. Dr. Kortüm (Cooktown) and Drs. Ahearne and Graham Browne were elected trustees, Drs. Cuthbert and Elliot auditors, and Dr. Humphry, curator.

A SURGEON is required for the hospital at Winton, in a pastoral district 1030 miles N.W. of Brisbane. He must be registered by the Queensland Medical Board before entering on his duties; salary, £400 per annum; three months' notice to be given or received; large private practice can be secured, as there is no other doctor in the district. The committee will find surgical instruments for the use of the hospital. Applications to be in the hands of the Secretary, Mr. W. S. Schollick, not later than the 12th August.

DR. C. M. AIRD, of Esk, has been appointed a Justice of the Peace.

DR. F. J. ELLIOT, of Townsville, has been appointed a Surgeon to the Queensland Defence Force.

DR. A. C. MACKENZIE, late Surgeon of the Birmingham General Hospital and Dover Hospital, has settled at Rockhampton.

DR. J. B. RYAN has settled at Warwick.

SOUTH AUSTRALIA.

DR. R. K. ARCHER, of Moonta, previous to his departure for Glenelg, was entertained by a large number of admirers, at the local Institute, on June 25.

DR. J. W. LEITCH has commenced practice at Kadina, a copper-mining town, 117 miles N.W. of Adelaide.

DRS. H. G. STEWART and J. A. STEWART have settled at Snowtown, 150 Miles N. of Adelaide.

DR. C. G. D. MORIER, of Nairne, has been appointed a Justice of the Peace for the colony.

VICTORIA.

In the Legislative Assembly on June 24, a "Bill relating to Medical Practitioners" was introduced by the Attorney-General and read a first time.

THE Board of Public Health have adopted regulations for the registration and supervision of private hospitals. The President at the same time stated that the Board recognized that while there was no necessity for any very strict supervision of private hospitals which were conducted by medical men, those which were managed by nurses, midwives, &c., should be subject to rigid inspection. The present regulations provided for both classes of hospitals. Private hospitals conducted by qualified medical men in any part of the colony will be registered by the Board, and be subject to inspection by the Board's officers. Hospitals not conducted by medical men will be open to local inspection only, subject to appeal to the Board.

ACCORDING to the statistics in possession of the Victorian Board of Health the number of deaths from diphtheria in 1887 was 64, in 1888 130, in 1889 329, and for the first four months of this year the number was 177.

At a recent meeting of the committee of the Melbourne Hospital a communication was received from the city coroner in reference to the recent inquest on James Wright, who died in the hospital while under chloroform. The jury recommended that a special officer should be appointed to administer anaesthetics at the hospital. The matter was referred to the medical committee.

At a recent meeting of the Committee of the Women's Hospital, Melbourne, a letter was received from Dr. Felix Meyer, the chairman of the honorary medical staff, on the question of opening the midwifery department to outside members of the profession. He stated that the feeling of the staff was that great care would have to be taken in the granting of the privilege. Each honorary member of the staff was willing that any medical man desiring to accompany them on their rounds through the wards could do so providing he was prepared to give a guarantee that he was free from every risk of conveying infection or contagion. The same condition would apply to the granting of permission to medical men desirous of witnessing operations. While perfectly willing to extend the ordinary courtesies of hospitals to members of the medical profession the honorary staff were fully alive to the risks of such extension, which applied with especial force to the lying-in department. The letter was received, and its recommendations approved of.

THE death is announced of Mr. Edmund Fleming Hayes, L. et L. Mid. K.Q.C.P. Irel. 1888, L. et L. Mid. R.C.S. Irel. 1888, who practised at Richmond (Melbourne) for the last eighteen months.

DR. A. W. CROOKS, a new arrival, has commenced practice at Warragul, 61 miles E. of Melbourne.

DR. C. A. DALY, late of Whitton (N.S.W.), has commenced practice at Mornington, 33 miles south of Melbourne.

DR. WM. DIAMOND has commenced practice at Omeo, 250 miles N.E. of Melbourne.

DR. E. H. EMBLEY has commenced practice at West Melbourne.

DR. J. S. LONG, late of Cooktown (Qu.), has commenced practice at Port Melbourne.

DR. R. L. MCADAM, late of Swan Hill, has commenced practice at St Kilda, a fashionable suburb of Melbourne.

DR. J. T. MITCHELL, late of Port Adelaide, has removed to Ballarat.

DR. A. W. F. NOYES, has removed from Carlton to 34 Collins-street, Melbourne.

DR. T. F. RIORDAN, late of Cork (Ireland), has commenced practice at 132 Nicholson-street, Fitzroy, a suburban city adjoining Melbourne.

WE regret to learn that Dr. Jos. Ross, of Warrnambool, was thrown from his horse on July 3, and dislocated his right elbow.

DR. J. CAM WIGHT has removed from Balaclava to Kensington, a suburb of Melbourne.

MEDICAL APPOINTMENTS.

Bacot, William Rickward, M.R.C.S.E., to be Health and Medical Officer at Geraldton, also Resident Surgeon of the Hospital for Pacific Islanders at Geraldton, Qu., vice Dr. T. G. White, resigned.

Byrne, Archibald Edward, L.R.O.P. Ed., L.F.P.S. Glas., to be Health Officer for shire of Glenelg, Vic.

Cook, Percival Robert, M.B. Univ. of N. Z., to be a Public Vaccinator for the district of Mount Benger, N.Z.

Coombe, Ethelbert Edred Sargeant, M.B. Durh., to be a Public Vaccinator in South Australia.

Cumming, William, M.D. of Ch. M. Ed., to be Government Medical Officer at Barcaldine, Qu.

Deek, Henry O'Brien, M.B. of Ch. B. Melb., to be an additional Public Vaccinator for the district of Nelson, N.Z.

Harrison, William Atkinson, M.B. of Ch. M. Ed., to be Public Vaccinator at Strahan and Zeehan, Tas.

Hawthorne, Alfred Wynter, M.D. of Ch. M. Roy. Univ. Irel., to be Government Medical Officer and Vaccinator for the district of Carcoar, N.S.W.

Hislop, Walter, M.B. Univ. N.Z., to be a Public Vaccinator for the district of Waikouaiti, N.Z.

Jackson, George Cecil, L.R.C.S.I., to be Officer of Health for shire of Minnamite, also Public Vaccinator at Macarthur, Vic.

Johnston, Arthur Alma, M.K.Q.C.P. Irel., L.R.C.S. Ed., to be Officer of Health for shire of Bulla, Vic., vice Dr. H. F. Hayes, resigned.

Monnell, Frederick William, L.R.C.S. Irel., L.K.Q.C.P. Irel., to be a Public Vaccinator in South Australia.

Myles, John, M.B. of Ch. B. Dubl., F.R.C.S.I., to be a Public Vaccinator for the district of Ross, N.Z.

Thornton, Philip, M.R.C.S. Eng., M.R.C.P. Ed., to be a surgeon in the Queensland Defence Force.


Williams, Frederick, M.R.C.S. Eng., to be Government Medical Officer and Vaccinator for the district of Balranald, N.S.W.

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UTERINE DILATORS, Ponsley's, 35s.; Schroeder's, 50s.; Madden's, 28s.;

&c., &c., &c.

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VITAL STATISTICS OF MELBOURNE AND SUBURBS FOR 1889.

THE estimated population of Melbourne and suburbs at the end of 1889 was 458,470, as compared with 437,785 at the same period of the previous year. There was thus an apparent increase of 20,685, or of 4.73 per cent. during the year. Of the increase referred to, only 6,521 was due to excess of births over deaths, the balance being attributable to immigration from the country districts and places outside the colony.

The total number of births during the year was 16,984, viz., 8,678 males and 8,256 females. In 164 instances twins were born, and as the births in the same period numbered in all 16,934, the confinements must have numbered 16,770. Thus one mother in 102 gave birth to twins. No case of triple births was recorded during the year. The births set down as illegitimate in 1889 numbered 1,184, or 109 more than in 1888. More than a third of these took place in the Women's Hospital or in buildings under the supervision of the officers of that institution. The proportion of illegitimate births to the whole number of births registered was 1 in 14, as against 1 in 15 in the previous year.

The total number of deaths recorded during the year was 10,413, viz., 5,692 males and 4,721 females, or 23.39 (including hospitals) per 1,000 of the mean population, while the birth rate was 38.04 per 1,000 of the mean population.

Of the births registered during 1889, 51 per cent. were of males and 49 per cent. were of females. Of the deaths during the year, 54 per cent. were of males and 46 per cent. were of females. Children under the age of 5 years contributed 44 per cent. to the total mortality, as against 42 per cent. in 1888 and 1887, 41 per cent. in 1886, 38 per cent. in 1885, 41 per cent. in 1884, 36 per cent. in 1883, 40 per cent. in 1882, 38 per cent. in 1881, and 40 per cent. in 1880 and 1879.

The deaths of 3,290 infants under 1 year of age occurred during 1889, the proportion being 19.44 to every 100 births. This was the highest infantile death rate that has occurred in the district during the last 17 years, the next highest being 19.39 in 1882. The corresponding proportion in 1888 was 17.18; in 1887, 17.51; and in 1886, 17.84. In the 16 years ended with 1888 the mean proportion to every 100 infants born of those who died before completing their first year of life was 17.08.

The deaths of 458 persons, viz., 244 males and 214 females, of the age of 75 years or upwards occurred during 1889, or 72 more than in the previous year. Of these, 215 were between 75 and 80, 153 between 80 and 85, 67 between 85 and 90, 18 between 90 and 95, 3 between 95 and 100, and 2 were stated to be 100 years of age.

The deaths due to *Zymotic diseases* were 1,802 (typhoid, 560, diarrhoeal diseases, 608, diphtheria, 328, whooping-cough, 179, &c.); *Parasitic diseases*, 32 (hydatids, 25); *Dietic diseases*, 160 (starvation from want of breast milk, 81, intemperance, 77); *Constitutional diseases*, 1,666 (phthisis, 923, cancer, 322); *Developmental diseases*, 608 (premature births, 287, old age, 240); *Local diseases*, 4,616 (enteritis, 755, pneumonia, 464, bronchitis, 353, heart diseases, 583, apoplexy, 210, convulsions, 249, croup, 136, dentition, 136, diseases of liver, 252, epilepsy, 71, &c.); *Violence*, 502 and 1,032 were ascribed to not specified causes.

BIRTHS, MARRIAGES, AND DEATHS.

. The charge for inserting announcements of Births, Marriages, and Deaths is 2s. 6d., which should be forwarded in stamps with the announcement.

BIRTHS.

BATEMAN.—June 27, at Manly (Sydney), the wife of A. W. Bateman, L.R.C.P., Ed., &c., of a son.
BOWKER.—June 14, at Darling Point, Sydney, the wife of Robert Steer Bowker, M.R.C.S., L.R.C.P., of a daughter.
BRADY.—June 21, at 5 Lyons-terrace, Hyde Park, Sydney, the wife of A. J. Brady, L.R.C.P., L.R.O.S.I., of a daughter.
BURTON.—On the 4th July, at Richmond (Melbourne), the wife of W. H. Burton, M.D., L.R.C.P.L., M.R.C.S. Eng., of a son.
GURDON.—On the 16th June, at Middle Brighton, Vic., the wife of Dr. B. J. Gurdon, of a daughter.
POCKLEY.—June 4, at St. Leonards, near Sydney, the wife of F. Antill Pockley, M.B., Ch. M., of a son.
SINCLAIR.—July 9, at Gladsville, near Sydney, the wife of Eric Sinclair, M.D., of a son.
STEVENSON.—June 14 at Longford, Tasmania, the wife of Frederick Stevenson, L.R.C.P.L., L.R.C.S.I. (late of Soane, N.S.W.), of a son.
WARREN.—June 16, at 285 Elizabeth-street, Sydney, the wife of W. Edward Warren, M.D., of a daughter.

MARRIAGES.

MASSEY-GAY.—June 4, 1890, at St. John's Church, Darlinghurst, Sydney, Harry M. Massey, L.R.C.P. Lond., M.R.C.S. Eng., Mt. Wychoeproof, Vic., to May, youngest daughter of the late John Gay, of Oeylon.
SOMERS-USHER.—On the 1st July, at St. Patrick's Cathedral, Ballarat, Vic., James Louis Edgeworth Somers, M.R.C.S., of Ayr (Qu.), to Frances Mabel Mary, eldest surviving daughter of Dr. J. F. Usher, Ballarat.
WILLIAMS-BLACKLEY.—On May 25, at St. Matthew's Church, Auckland, Dr. T. O. Williams, Resident Surgeon of the Thames Hospital to Maggie Blackley, both of Thames N.Z.

DEATHS.

POPHAM.—On the 10th of June, at Gawler, S.A., from pleurisy, Julia Louisa Popham, aged 37 years, wife of Francis Wm. Home Popham, L.R.C.P., M.R.C.S.E.
SAMSON.—On the 27th June, at Ararat, Vic., Lionel, son of Dr. Henry Sampson, aged 5 years and 5 months.
WELD.—On the 17th June, at Warraknabeal, Vic., Annie Kathleen, wife of Dr. J. O. Weld, in her 27th year.

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History and Pathology of Vaccination. By Edgar M. Crookshank, M.B., 2 vols. London: H. K. Lewis, 1889.
Insomnia and its Therapeutics. By A. W. Macfarlane, M.D. London: H. K. Lewis, 1890.
On the Diseases of, and the Operations on, the Mastoid Process; Pseudo-Hay Fever, Symptoms and Treatment; Antiseptic Ophthalmic and Aural Surgery; On the local treatment of Non-suppurative Diseases of the Middle Ear. By Adolf Bronner, M.D., 1889.
Original Contributions to Ophthalmic Surgery. By J. R. Wolfe, M.D., F.R.C.S.E. London: J. & A. Churchill, 1890.
Athembewegung und Herzaktion asphyktischer Früchte. By Prof. Dr. B. S. Schultze, Jena.
Ueber die Wiederbelebung tief Scheintodt geborener Kinder. By Prof. Dr. B. S. Schultze, Jena.
Addresses delivered at the formal opening of the new building of the Biological Department of the University of Toronto. December 19, 1890.
Official Record of the Proceedings and Debates of the Australasian Federation Conference held in Melbourne. 1890.

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A New Medical Dictionary. By George M. Gould, A.B., M.D. Philadelphia: P. Blakiston, Son & Co. 1890.

Tenth Annual Report of the State Board of Health of Illinois. 1890.

Short Contributions to Aural Surgery. By Sir Wm. B. Dalby, F.R.C.S., M.B. (Cantab.). London: J. & A. Churchill, 1890.

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A Text-Book of Obstetrics, including the Pathology and Therapeutics of the Puerperal State. By Dr. F. Winckel; translated by J. Clifton Edgar, A.M., M.D. Philadelphia: P. Blakiston, Son & Co. 1890.

Text-Book of Medical Chemistry. By Elias H. Bartley, B.S., M.D. 2nd Edition. Philadelphia: P. Blakiston, Son & Co. 1890.

Massage and the Original Swedish Movements: their application to various diseases of the body. By Kurre W. Ostrom. Philadelphia: P. Blakiston, Son & Co. 1890.

Special Hospitals for the Treatment of Tuberculosis. By Lawrence F. Flick, M.D. Reprinted from *The Times and Register*, March 15, 1890. Philadelphia.

Importance of Oedema of the Vaginal Portion of the Cervix Uteri as a symptom of Chronic Disease. By Andrew F. Currier, M.D. Reprinted from *Gynecological Transactions*, 1889. New York.

A case of Uterus Bicornis Unicollis, with Parenchymatous Abscesses of the Portio-Vaginalis. By Andrew Currier, M.D. 1890.

Wattles and Wattle-Barbs. By J. H. Maiden, F.L.S., F.C.S. Sydney: Charles Potter, Government Printer, 1890.

A Report on Medical Education, Medical Colleges, and the Regulation of the Practice of Medicine in the United States and Canada, 1765-1890. By John H. Rauch, M.D., Secretary of the Illinois State Board of Health. Springfield, Ill., 1890.

BIRTHS AND DEATHS IN AUSTRALASIA DURING 1889.

COLONY.	Births.			Deaths.			Per 1000 of Mean of Pop'n	
	Males.	Females.	Total.	Males.	Females.	Total.	Births.	Deaths.
New South Wales	19,286	17,949	37,235	8,687	6,142	14,829	33.73	13.43
Victoria	18,714	17,674	36,388	11,040	8,332	19,372	32.95	17.54
Queensland	7,449	6,952	14,401	3,930	2,202	6,132	36.27	15.44
†South Australia... ..	5,286	5,082	10,318	1,966	1,535	3,501	32.64	11.07
Western Australia	825	769	1,594	412	199	611	37.14	14.24
Tasmania	2,438	2,319	4,757	1,208	890	2,098	31.97	14.10
New Zealand	9,514	8,943	18,457	3,356	2,416	5,772	30.07	9.40
Total Australasia... ..	63,512	59,638	123,150	30,599	21,716	52,315	33.04	14.04

† Not including Northern Territory.

VITAL STATISTICS OF CHIEF AUSTRALASIAN CITIES, 1889.

Chief Cities, including Suburbs.	Approximate mean Population.	Births.		Deaths.		Excess of Births over Deaths.	Deaths under 1 year.	Deaths under 1 year per 1,000 Births.	Total Deaths under 5 years.
		Total Number.	Per 1,000 of Population.	Total Number.	Per 1,000 of Population.				
Sydney	347,207	13,344	35.66	6,338	16.94	7,006	2,301	172.44	3,239
Melbourne	445,220	16,924	38.01	10,415	23.39	6,509	3,290	194.40	4,627
Brisbane	86,000	3,963	46.08	1,572	18.28	2,391	620	156.45	851
Adelaide	120,600	4,239	35.15	1,856	15.39	2,383	491	115.83	698
Hobart	34,560	1,054	30.50	699	20.22	355	164	155.60	204
Wellington... ..	32,125	981	30.54	405	12.61	576	115	117.23	155
Perth	9,000	363	40.33	179	19.89	184	49	134.99	60

REPORTED MORTALITY FOR THE MONTH OF MAY, 1890.

Cities and Districts.	Population.	Births Registered.	Deaths Registered.	Deaths under Five Years.	Number of Deaths from									
					Measles.	Scarlet Fever.	Croup and Diphtheria.	Whooping Cough.	Typhoid Fever.	Dysentery and Diarrhoea.	Phthisis.	Heart Disease.	Cancer.	Child-bearing.
N. S. WALES.														
Sydney	128,880	281	140	39	..	...	2	...	...	3	24	9	2	1
Suburbs	252,850	849	270	111	..	2	17	2	1	10	34	19	6	3
NEW ZEALAND.														
Auckland	33,307	78	84	9	...	...	1	...	3	3	2	1	2	...
Christchurch...	17,116	30	19	3	...	...	...	...	...	4	1	3	...	...
Dunedin	24,168	40	29	7	...	...	...	...	3	1	5	3	1	...
Wellington	31,028	63	41	9	...	...	1	...	1	1	3	7	1	2
QUEENSLAND.														
Brisbane	51,689	212	84	34	}	2	15	...	2	6	9	6	7	...
Suburbs	21,960	151	35	22										
SOUTH AUSTRALIA.....														
Adelaide	319,138	963	444	165	...	...	31	11	12	15	40	21	8	3
Adelaide	44,581	101	114	31	...	...	4	4	5	4	17	7	2	1
TASMANIA.														
Hobart	35,854	126	78	15	...	...	1	...	2	...	4	8	2	1
Launceston.....	22,062	61	39	11	...	...	2	2	1	...	2	3	...	...
Country Districts.....	94,490	251	93	...	...	...	4	1	2	2	...	...	...	...
VICTORIA.														
Melbourne	75,400	151	115	244	..	2	53	...	36	12	93	63	26	8
Suburbs	362,385	1,461	684											

METEOROLOGICAL OBSERVATIONS FOR MAY, 1890.

STATIONS.	THERMOMETER.					Mean Height of Barometer.	RAIN.		Mean Humidity.	Prevailing Wind.
	Maximum Sun.	Maximum Shade.	Mean Shade.	Minimum Shade.	Mean		Depth.	Days.		
Adelaide—Lat. 34° 55' 33" S.; Long. 138° 36' E. ....	...	75.2	58.6	44.5	50.023	Inches	...	...	...	...
Auckland—Lat. 36° 50' 1" S.; Long. 174° 49' 2" E.	125.6	68.7	57.2	40.7	...	4.330	20	74	...	...
Brisbane—Lat. 27° 28' 3" S.; Long. 153° 16' 15" E.	123.9	76.1	68.1	50.1	30.157	1.585	13	79	s.	...
Christchurch—Lat. 43° 32' 16" S.; Long. 172° 38' 59" E.	120.6	69.6	46.7	24.7	...	.982	8	73	...	...
Dunedin—Lat. 45° 52' 11" S.; Long. 170° 31' 11" E.	108.8	58.7	45.8	33.7	...	2.104	14	79	...	...
Hobart—Lat. 42° 53' 32" S.; Long. 147° 22' 20" E. ....	...	68.5	52.8	38.8	30.134	1.09	10	84	...	...
Launceston—Lat. 41° 30' S.; Long. 147° 14' E. ....	...	67.5	52.9	35.7	30.186	0.95	7	87	...	...
Melbourne—Lat. 37° 49' 54" S.; Long. 144° 58' 42" E. ....	...	73.5	54.4	37.7	30.112	2.35	11	...	...	...
Sydney—Lat. 33° 51' 41" S.; Long. 151° 11' 49" E. ....	...	68.1	59.0	49.4	30.201	8.45	19	82	w.	...
Wellington—Lat. 41° 16' 25" S.; Long. 174° 47' 25" E.	110.7	68.7	52.3	37.7	...	3.859	18	74	...	...

AUSTRALASIAN MEDICAL GAZETTE.

ORIGINAL ARTICLES.

NOTES OF A SEVERE CASE OF LIGHTNING-STROKE, ENDING IN RECOVERY, WITH REMARKS.

BY PHILIP JAMES, F.R.C.S., ENG.,
OF CROYDON, NORTH QUEENSLAND.

P. J. F. *ætat* 43 years of age, was in his hut on December 14, 1889, during a violent thunder-storm. Eighteen hours afterwards he was discovered by his friends speechless, and in a condition of partial unconsciousness, and was brought into town on December 16, when I first saw him.

On examination, it was found that the hair on the right side of the median line of the head, below the level of the occipital protuberance, and that of his whiskers at the angle of the jaw on the same side, was scorched; there was an erythematous blush (subsequently followed by vesication) on the right cheek and the corresponding side of the nose; and a thin red line could be traced along the sternum, slightly to the right of the middle line and extending along the abdomen to the pubes, where the hair was very severely burnt. The skin along this line afterwards desquamated. The hair of both legs was also singed, while on the outer aspect of both heels the skin was burnt. His mind was clear, and he showed a perfect apprehension of everything that was said to him. He had no recollection of anything that had occurred. His speech was almost unintelligible, and he was much troubled by a copious secretion of viscid tenacious mucus in the mouth, which he experienced great difficulty in ridding himself of.

On testing the plantar reflex, the legs were promptly and strongly drawn up; the cremasteric and abdominal reflexes were normal, as also the patellar tendon reflex. There was no clonus. Tested roughly, there was no loss of squeezing power in the hand, and no appreciable difference between right and left. The tongue was firmly protruded, without deviation to either side, and showed no alteration in form. He complained of pain in the throat, and the act of deglutition was much impaired, fluids regurgitating freely through the nostrils. He was unable to micturate, but retained partial control over the anal sphincter. Although his legs showed no loss of power when tested separately, his ability to co-ordinate was quite gone. He was unable to maintain his equilibrium. The pulse was full, and very slow—44 in a minute. Respiration, 11-12. Temperature normal.

Special Senses.—The pupils acted well to light, were equal and of normal size. The eyes were kept closed, as he said the light hurt him. Several days later it was noticed that there was slight drooping of the left eyelid, and he said that sometimes he saw double. There was no perceptible squint, but on carefully testing the internal rectus muscle it was noticed that although it could converge almost or quite as well as the right it tired more quickly, and the eye deviated. The difference in the pupils was scarcely perceptible. He heard everything that was said to him, and, so far as could be ascertained, the senses of smell and taste were normal. His speech was very indistinct.

Progress.—Without going into details it may be stated generally that his improvement was uniform but slow. The pulse and respiration gradually quickened up to the normal, and the power of swallowing improved day by day. At the end of the first week he became more restless and difficult to manage on account of pains, as he expressed it, "all over me." These were much relieved by friction. On January 3rd he passed his urine voluntarily for the first time, and in a fair stream. However, for some time it was found necessary to practise catheterism. A week later he could hold his water for longer periods and he could walk a few feet without aid.

On the same date, January 3rd, a weak Galvano-Faradic current was tried and a day or two later he began to pass large quantities of flatus per anum, while accompanying these discharges was an occasional escape of fecal matter.

Treatment.—There is nothing special to note. For the first day or two stimulants such as ammonia and ether were ordered, and when reaction had set in mercury was resorted to with the view of obviating any possible inflammatory complication. When this danger seemed past he was placed on quinine and strychnine, and the galvanic battery was cautiously tried. An occasional hypodermic of morphia completes the list.

Remarks.—Medical literature is singularly barren of anything like accurate knowledge of the pathology of these injuries. This must be my excuse for trespassing at such length on your valuable space. This case is to me one of singular interest, not only on account of the severity of the injury, but from the fact that he lay nearly twenty-four hours before he was discovered, and most of all from the fact of his almost complete recovery. Some of the symptoms are susceptible of more than one explanation.

The reflex and voluntary movements of the legs were unimpaired, showing that the sensory and motor paths in the cord were open. However, on attempting to stand he was quite unable to maintain his balance, and would have fallen had he not been guarded. This undoubtedly meant some injury to the middle lobe of the cerebellum. The difficulty of swallowing was possibly due to some lesion affecting the nuclei of the vagus and glossopharyngeal nerves forming the pharyngeal flexus; and if it be true that the glossopharyngeal derives its motor fibres from the spinal accessory, then this nerve must also be included within the scope of the injury.

Unless the paralysis of the velum palate and of the pharynx, together with the large amount of viscid tenacious mucus present in the mouth, be accepted as a sufficient explanation of the defect in his speech, the problem becomes more difficult of solution, there being no paralysis of the hypoglossal nerve.

The vesical paralysis is, to my mind, capable of two or three explanations, one being that the micturition centre in the lumbar cord was rendered unable to act. If this were so then it might be expected that the bladder would become distended without the patient's knowledge, and the urine overflow. As a matter of fact the patient was acutely conscious throughout of the desire to micturate. Another possible explanation is that the electric current exercised a local paralyzing effect on the muscular coat of the bladder. The third view is that the controlling centre in the cerebrum was at fault. The second and third both appear feasible, but on the whole I am disposed to think that the failure arose from a suspension of function in the cerebral centre, which by some authorities is supposed to lie in the optic thalamus. This view would seem to be borne out by the condition of the anal sphincter. It will be remembered that this was said to be only partially paralyzed; he was quite conscious of the approaching act of defecation, but was sometimes unable to control the sphincter for a sufficient time to avoid unpleasant results. In the dog, when the spinal cord is divided at the level of the fourth or fifth lumbar vertebra, and a stimulus is applied to the bowel in the region of the anus, a momentary contraction of the sphincter is seen. This, however, almost instantaneously disappears, and the bowel discharges its contents. Physiologists assert that there are in the brain, somewhere in the neighbourhood of the micturition centre, two centres, one of which augments the action of the sphincter ani, the other being inhibitory. Now, the fact that he was able to exercise partial control over the sphincter seems to me to prove that the controlling centre in the cerebrum was

partially disabled. Had the disability being total then the condition of things would have been the same as indicated in the experiment on the dog. If this be so then it bears out my view that the bladder trouble arose from a failure in the cerebral centre also. A noticeable feature in the case was the restlessness and vague pains complained of after the first week: a condition presenting an analogy to the pain felt when sensation is returning to parts that have been exposed to cold. Bearing in mind the third law of motion this hyperæsthesia would seem to imply a previous anæsthesia, but none was perceived at the time. The symptoms above recorded point strongly to some lesion affecting the middle lobe of the cerebellum, the medulla, the cord as low as the origin of the phrenic nerve, and to a lesser extent the great basal ganglia, the brunt being apparently borne by the cerebellum.

Such appears to me to be the physiological interpretation of the various phenomena. The pathology of these injuries is shrouded in mystery. It is generally considered that the nature of the injury is concussion, and there is no doubt, when we remember that thunder is caused by the violent expansion of air in the path of the lightning, that this atmospheric disturbance must be sufficiently great to cause very violent concussion. The only additional suggestion I have to make is whether there may not be some chemical or chemico-physical injury akin to electrolysis. The following is the order in which the paralyses disappeared:—1. Sphincter ani; 2. Bladder; 3. Ptosis and diplopia; 4. Swallowing and speech. When he returned to his friends on February 4 there was still tottering gait and general muscular weakness.

May 2.—On this date the patient, who was on his way to Victoria to his relatives, called to see me. He had greatly improved, but was still weak. He was able to walk at a fairly rapid pace, but his gait was jerky and he lifted his feet rather high. He could not, however, be called ataxic, and the knee-jerk was not impaired. He complained of frequent "pins and needles" in his feet, and of something "being wrong" in his head. His memory is defective and his conversation somewhat fatuous. Although his recovery has been little short of marvellous he is a shaken man.

It will be of interest to know, as bearing on the prognosis in future cases of the kind, whether his present level is a permanent one, or whether he will still improve or gradually drift into dementia.

He is now in Wangaratta (Victoria).

Croydon, Queensland,

June 25, 1890.

FEVERS OF THE PUERPERAL STATE.

READ BEFORE THE MEDICAL SOCIETY OF
QUEENSLAND.

BY WILLIAM S. BYRNE, A.B., M.B., PRESIDENT
MEDICAL SOCIETY OF QUEENSLAND
AND HON. PHYSICIAN TO THE BRISBANE
AND LADY BOWEN HOSPITALS.

I INTENTIONALLY use the words "Fevers of the Puerperal State" instead of puerperal fever—a name without a precise meaning—and it will be my aim this evening to initiate a discussion which cannot fail to be of help to us in dispelling the fog which clings around this term which means so little and so much.

Firstly, I shall divide these fevers into two great classes, the non-septic and the septic. The former I shall further divide into two classes, viz., the simple and the sapræmic; and although the latter rather tends towards the septic form I prefer for the present to place it in the non-septic division.

To take simple fevers first and subdivide them according to their causes we have, firstly, traumatic, such as bruising of maternal soft parts, lacerations of cervix and perinæum, inflammatory hæmorrhoids and cystitis; and secondly, idiopathic, such as mammary troubles, development of milk, sore nipples, abscess of the breast and phlegmasia dolens.

I am sure that many cases of temperature after parturition which give us uneasiness are caused by injuries sustained by the mother during the passage of the foetal head. I had a telling example of this about a month ago. I was sent for by a midwife to attend a primipara, and asked to bring the instruments. On my arrival I found the head dilating the orifice of the vagina, and on making enquiries I found that matters had been so for six hours. The parts were much swollen and tender. Forceps were not necessary, for shortly after my arrival a severe pain occurred which expelled the head, rupturing the perinæum to the anus. Afterwards, when about to unite the perinæum by sutures, I was struck by the appearance of the vaginal walls, which were of a dirty blue colour, and looked more like gangrene than anything else. This case had a temperature of 102° next day, and it ranged from 100° to 105° until the seventh day, when it fell to normal. I look upon this as a severe and typical case of traumatic fever, and the possibility of its occurrence is an argument in favour of the early application of forceps. When there is delay at

the end of the second stage of labour perinæal rupture and laceration of the cervix are capable of raising the temperature one or two degrees on the second or third day. Cystitis has occurred in my practice now and then, not of a very acute form certainly, but still enough to give a temperature of 100° or thereabouts. Inflammatory hæmorrhoids are a fruitful cause of fever, as you all will have noticed.

Now in regard to the idiopathic subdivision, mammary troubles head the list. Sore nipples may *per se* elevate the temperature, and they usually cause more or less inflammation of the breast, which sometimes leads on to abscess. Here there is an interesting point which now presents itself, namely, how often is breast abscess due to pyæmia? Or practically speaking, is breast abscess after parturition sometimes due to pyæmia? I am not sure, but I rather fancy I had a case of this nature a few months ago, of which I shall give you a brief outline. Mrs. M., aged about 28, had a natural labour with her third child on last Christmas Day. The placenta was expressed, and apparently everything came away. On the third day, however, the temperature began to rise, the lochia became offensive, and two rigors occurred. The temperature mounted up to 104·6° on that night, and for ten days after wavered between 100° and 108°. The offensive discharge continued. It now assumed the appearance of pus, and on the thirteenth night she had another rigor with a temperature of 105°. Two days after an abscess of the breast formed, with no throbbing, no local heat or redness, and no pain, the patient only complaining of soreness; and this latter symptom appears to be characteristic of pyæmic abscess, that it forms without much local pain, and that attention is drawn to it simply on account of the soreness. The temperature, after the abscess was opened, declined, but not to normal, and the patient went on fairly well for another week, when she again had a rigor, and complained of soreness in the other breast, and a lump was felt, which, however, ended in resolution, and the patient recovered perfectly after six weeks' of bed. I may mention that the uterus was curetted and syringed, but without any membrane or placenta being found. This case certainly suggests to me the possibility of pyæmia, and I lean to that explanation of the symptoms. The development of milk is questioned in high places as a cause of fever, but certain it is that commonly we meet with cases which on the third day have a temperature of 100° or thereabouts, headache, frequent pulse, sometimes a slight rigor, and swelling and hardness of the breasts—symptoms which are followed by a large milk supply. That

is what I should term milk fever, but there is no doubt that, like puerperal fever, the term has been loosely applied to other feverish states which have no connection with the milk whatever. I place phlegmasia in the non-septic division because it is a debatable point as to whether it is a septic disease or not. It is questionable whether we get pelvic inflammation apart from septic mischief, though there is no reason why we should not. Before closing the non-septic list there is one fever not connected with the puerperal state which we sometimes get in low-lying ground, and ground which has recently been turned up, and that is the intermittent variety. I was rather puzzled over one case lately where a temperature kept alternating between normal and 105° for some three weeks after labour. Dr. Thomson kindly saw the woman in consultation with me, and suggested that explanation, and I fancy he was right. The house was low-lying, and the road leading to it had recently been repaired. *

Sapræmia, or putrid intoxication, is due to the absorption by the blood of poisonous chemical substances, septic infection to the entrance into living tissues of known pathogenic organisms. In sapræmia the poisoned blood is fed from the origin of the putrefaction, and if that origin can be cleared away in reasonable time, whether it be decomposing clot, membrane, placenta, or polypi, the symptoms abate. The germs in sapræmia do not multiply in the blood, thus sharply distinguishing it from septicæmia. It appears that "germs do not progress beyond the internal os into the uterine cavity." (Bumm, *Archiv für Gyn.*, xxxiv., 3). Bumm has made several experiments on fluid which has been on the uterus for some considerable time, and always found it sterile, and he is further of opinion that the reason is that the germs lack the power of locomotion, and because mechanical aids fail them when they reach the internal os. So that, in order that retained substances in the uterus should undergo decomposition, germs must gain access either from the fingers or instruments, or from what is much more common, shreds of membrane hanging from the cavity of the uterus into the vagina. This at once explains why we get cases of placenta retained for months without undergoing any change or causing any other symptom than hæmorrhage, whilst in others alarming symptoms show themselves after a few days. The interesting question now arises as to whether sapræmia can go on to septicæmia, and also if infection from putrid intoxication will produce in another case, septicæmia. It is an established fact that in all epidemics of so-called puerperal fever the com-

mencement is always of a mild type, which gradually increases in virulence till the most malignant form is reached. According to Dr. Burdon-Sanderson's views, which are the result of experiments, if the exudation of a simple peritonitis be injected into the peritoneum of another animal, the disease assumes a more active form than in the first instance, and so on, gradually developing this tendency, until at last a virus is reached of the virulence of malignant peritonitis in the human subject, "This gradual evolution from traumatic infectivity to the intensified virulence of malignant septicæmia teaches plainly what we could not otherwise learn" (Burdon-Sanderson). This lesson informs us that a woman who has not any fever whatever, but say an offensive discharge from a decomposing clot or placenta, is capable of infecting another woman with a distinct disease, which we call septicæmia, and if you grant this proposition, why should she not be able to infect herself? To put the case more plainly, we will suppose a woman to have had a fairly good labour, she has, however, sustained a laceration of the cervix, some pieces of membrane have remained in the uterus and are undergoing decomposition; she suffers from an offensive discharge, and she develops a fever. She is now suffering from sapræmia or putrid intoxication, and if the offending material be not removed at once she runs a grave risk of incurring septicæmia. If the foetid discharge infects the lacerated cervix, some series of changes take place, the evolution theory of Dr. Sanderson steps in, and a severe form, maybe, of septic mischief ensues. This is a fair case of autogenetic septicæmia, and a cause which explains many fevers over whose origin our minds are exercised. I think sapræmia and septicæmia are two distinct diseases, but that the latter may be evolved out of the former, with ease. The absorption of meconium, when it escapes into the genital tract, causes sapræmia. I had an example of this only six weeks ago. After the child was born naturally, a rush of meconium ensued, a condition I have never before seen, and on getting the uterus contracted, still more escaped. I carefully irrigated the vagina, but the woman had a temperature of from 100° to 103° for about ten days.

It is difficult to say where sapræmia ends and septicæmia begins, and I think you will agree with me that there is such a condition as sapræmic septicæmia. Dr. Lombe Atthill points out as a cause of puerperal fever non-contraction of the uterus after delivery (which is common in single women), and explains the course of events in this way: "The muscular fibres of the organ do not contract as they should, the blood supply is consequently cut off, the mouths of the sinuses

* Since writing the above I find Dr. More Madden describes a puerperal fever which he calls intermittent.

remain open, the denuded placental site, instead of becoming rapidly restored to its normal condition, becomes unhealthy, and the foetid discharge enters the system through the placental sinuses or is absorbed through some fissure." Now is a case of this kind sapræmic septicæmia? I should think so. The septic mischief arises from the absorption of the decomposing endothelium at the placental site, and I believe that early irrigation and strict antisepticism would in a great measure check the onward progress of the trouble. The septic division of course comprises pyæmia and septicæmia, and the latter I shall subdivide into local and general. By local septicæmia I mean those cases of pelvic mischief which although septic in origin, do not extend into the more dangerous and malignant general form, but stop short, as it were, at a salpingitis, a metritis, or a pelvic cellulitis.

General septicæmia may be mild or severe. We occasionally see cases which have a temperature for days and weeks after delivery with no local signs to account for it, cases which are never in a very dangerous state, and which gradually get well. On the other hand those terribly swift cases of the malignant form, complicated with peritonitis, are but little amenable to treatment and are our terror and our bane. Uterine phlebitis must be mentioned as a not uncommon septic fever, and a case of internal erysipelas has been recorded by Doederlein of Leipsic, in the German Gynecological Association reports. Doederlein states that he found the streptococci of erysipelas both in the lochial discharge and in the joints after death. In fact the connection between erysipelas and puerperal septicæmia is worthy of grave attention.

Now come the practical questions of this paper, questions which I trust will evoke the greatest amount of discussion, for it is only by debating thoroughly and threshing out disputed points that we can at last arrive at a conclusion approaching the truth. Firstly, is sapræmia or septicæmia occurring in a puerperal patient capable of being communicated to another puerperal patient by any other means than a direct transfer of the infectious matter living the genital tract? and secondly, are all forms of septic mischief infectious? On the settlement of these two questions hang serious issues, and we cannot underrate their importance. Lombe Atthill gives it as his decided opinion, and it is one we must all respect, that infection is impossible through the medium of the air breathed by the patient; and I believe that is the generally accepted opinion at present, so that we are narrowed down to the theory of direct infection through instruments, sponges, syringes, fingers, and a host of other

things. I may mention in passing, however, that Dr. Atthill also expresses his opinion that there is an epidemic form of so-called puerperal fever, which is different in its symptoms to the usual septicæmia we meet with in isolated instances, and which he says spreads in the same way as other ordinary epidemics, but which is of a non-septic character, that it is in fact a special fever like typhoid or scarlatina. Certainly if Dr. Atthill's first axiom is correct, that septicæmia is only directly communicable by infection from the discharges, and there is no aerial influence, an explanation is surely required as to the cause of an epidemic, and whether his explanation, ingenious as it is, is satisfactory or not, I leave it to you to say. As far as I personally am concerned, I should not like to make the assertion that it is not possible to communicate it through other agencies than direct infectivity. As to whether all septic disease is infectious, I am very doubtful. I am convinced, however, that it is possible, nay, even likely, to infect a puerpera with septicæmia from a sapræmia. One can get a peritonitis, a metritis, or a cellulitis, doubtless, of septic origin, without having a general septicæmia, and I am not at all sure that these cases are in the slightest degree infective. I am inclined to think, however, that many of the pelvic fevers we meet with after labour, such as salpingitis, metritis, pelvic peritonitis, &c., are not of septic origin, but arise from some injury sustained during parturition. The system of the puerperal woman is peculiarly liable to inflammation, and what might be a slight injury at another time gives rise after parturition to the gravest symptoms. I will even say, that taking fevers of the puerperal state all round, that septicæmia is not so common as may be supposed, though it is a good rule to accept every fever as septic till time proves the contrary. Many cases of septic mischief arise, not from any fault on our part or from infection from another puerpera, but from a filthy condition of a nurse or midwife, whose nails as we sometimes see them, are of a most funereal hue. The gross ignorance prevalent among some of these women of the advantages of cleanliness is a matter to be deplored, but I am thankful to say the old race of midwife is dying out, though not so fast as I could wish, and is being replaced by young and educated nurses who understand at all events some of the elements of anti-septicism. Dickens' Sarah Gamp is not dead, and until we have a registered midwife, whose qualification shall be a guarantee of education in her art, Mrs. Prig will continue her career of slaughter. Puerperal fevers, gentlemen, are an interesting study, and I trust my small efforts will lead to a discussion which will benefit us all.

PROCEEDINGS OF SOCIETIES.

NEW SOUTH WALES BRANCH OF THE BRITISH MEDICAL ASSOCIATION.

THE 91st general meeting was held in the Royal Society's rooms, Sydney, on Friday, 4th July. Present: Dr. G. T. Hankins (President), in the chair, Drs. Scot-Skirving, Fiaschi, Knaggs, Wm. Chisholm, Jenkins, Clark, Crago, W. J. O'Reilly, Hodgson, Marano, Lyden, Faithfull, Milford, Reading, Pockley, Rennie, Traill, Worrall, G. A. Marshall, Newmarch, Cohen, McDonagh, Sydney Jones, Martin, West, Graham, Huxtable.

Visitors: Drs. Goode, Gardner, Sheldon.

The minutes of the previous meeting were read and confirmed.

The PRESIDENT informed the meeting that the deputation appointed to wait upon the Government to urge the necessity for the completion of the Sydney Hospital had deferred their visit, owing to the illness of the Premier, who desired to personally receive the deputation.

Dr. SCOT-SKIRVING, in reading the following notes on influenza as observed in Sydney, premised by remarking that he had nothing new or startling to promulgate, but merely desired to submit an outline of the character of the epidemic which had visited us, and hoped discussion would be evoked thereby. From the 7th May he had seen 52 cases of the disease.

INFLUENZA AS OBSERVED IN SYDNEY.

By R. SCOT-SKIRVING, M.B. ET CH.M. EDIN.,
LECTURER ON CLINICAL MEDICINE AT THE
SYDNEY UNIVERSITY, AND PHYSICIAN TO
THE PRINCE ALFRED HOSPITAL.

It seems to me right that medical men practising in out-lying communities which have been visited by the recent epidemic Influenza should, in such a society as this, put their observations on record, and to this end I have made a few notes of cases which have been treated by me in the hope that a discussion of the various points of interest in regard to the disease may thereby be called forth.

I will very briefly summarize my cases. Up to May 27 I had seen certainly 52 cases of this disease, either during or subsequent to the acute symptoms. The first noted was on March 25.

As to Symptomatology.—Most of these patients complained of a condition of general *malaise* and chilliness for twenty-four hours before the urgent symptoms, of "the stage of advance" to use the stated terminology of febrile disease. A smaller proportion had a much shorter period of invasion; for instance, in two or three instances they went to bed well and awoke ill. The stage of advance seems to be characterized by several cardinal symptoms: 1. Pains in the bones, joints and

muscles, notably in the back. 2. Headache more or less intense, mostly I think, frontal. 3. Pyrexia. The pains have been intense and most distressing to the patient. So much did they loom large to my mind that the first case seemed to me like the beginning of acute rheumatism. The headache also has been of a very intense character, and I listened to many complaints of intense throbbing pain in the eyeballs. The pyrexia has been sudden in rise, varying from 100 to 104 in severe cases, lasting usually about forty-eight hours and then subsiding rapidly, the skin during this period being hot and dry. The pulse quickened in proportion to the temperature, or rather more so. A rigor was not an infrequent event. Most of my cases were convalescent in three days from the time of invasion, some ran on to five days. I would here note with some emphasis the comparative insignificance, nay, the not infrequent entire absence of catarrhal symptoms. True, the eyes were in a large number of cases suffused, but absence of definite nasal catarrh seems to me almost a feature of this epidemic. In some few cases out of the whole number violent gastro-intestinal symptoms appeared. Either vomiting and retching, or diarrhoea, or both combined. The ordinary pain at the costal margins and epigastrium very much exaggerated in such cases of continued vomiting. Relapses occurred in about five instances, largely due, I believe, to too early getting about.

Some tracheal and bronchial catarrh occurred as a sequence to the majority of my cases, at least they had a worrying cough and some viscid sputum, and felt miserable.

Bronchitis of a pronounced character I saw six or seven times, broncho-pneumonia four times, and hæmoptysis once.

Twice I noted a marked erythematous flush over the skin.

I regret I have no notes of the condition of the urine, other than that it was scanty in many instances and deposited urates.

A condition of debility, profound in a degree when compared with the time of being ill, and even with the severity of the illness, seems also to me to be a salient feature in these cases, and this state continued not a little time.

My patients presented almost equal numbers as to sex, but certainly infancy and early childhood did not suffer in the same proportion as in adults; indeed I saw no case under four years of age. I have imagined that women were specially liable to take this complaint, and to be specially ill from it, at the menstrual period, but this idea probably is only based on a series of coincidences. My hospital practice did not contribute a single case. All those on which these remarks are

based were met with in private practice and in comfortable conditions as to food and surroundings and occupations. I saw no instance in which I could infer that the disease had been communicated from one person to another, but I may add the following suggestive fact, communicated to me by a naval officer, viz., that the sequence of cases on board one of Her Majesty's ships while at sea occurred in men who slept in hammocks contiguous to each other. As he expressed it, "it travelled along the rows one after the other."

DR. HODGSON, before reading his notes, said he also hoped discussion would ensue.

JOTTINGS TO PRODUCE DISCUSSION ON INFLUENZA.

By R. HODGSON, L.R.C.P., LOND., M.R.C.S. ENG.

LEARNING that initiatory notes in the discussion on a prevailing topic would also be presented to you by my coadjutor, Dr. Skirving, and feeling well assured his masterly hand would expose various subtle and intricate factors of the disease, I thought it better my half of the work should elicit generalities, instead of diving deeply into detail. Hence my inaugural comments read as follows:—

My first case occurred on the 19th March in a girl aged 10 years, and the last case up to the date of writing this paper was on the 23rd May, 1890.

Numerous similar attacks quickly followed the first, and the epitome of clinical observations appended herein is separated into different heads, that discussion may be simplified and proceed in an easier and more methodical manner.

The divisions I thought it better to recognize are:—*Incubation, Invasion, Symptoms and Course, Relapse, Convalescence, Differential Diagnosis, Treatment.*

Incubation.—According to my experience the incubation ranged between two days and eight days. One family of three all exhibited a latency of eight days. Probably the infection was most virulent in the early stages, say on the first or second day of disease.

Invasion.—The invasion was sudden, and the illness seemed to attain its maximum discomfort within 12 hours of seizure.

Symptoms and Course.—The first symptoms were pyrexia and severe myalgia, particularly of the upper dorsal and posterior femoral regions. In the early stage of the epidemic the dorsal pains predominated over those of the thighs, but towards the end of the morbid wave I noticed the inferior extremities suffered more than other parts. The myalgia was not commensurate with the rise of temperature. It commonly persisted

for a day or more after the extinction of pyrexia. Cephalalgia was most aggressive over the frontal sinuses, and orbital pains were a somewhat marked feature of the disorder. To my mind the assertion that frontal headache is due to involvement of the sinuses is not proved, and I think it might more reasonably be considered, together with the other pains, as central in origin. In cold countries the facial air cavities undergo catarrhal inflammation, and when pain occurs over these regions it is ascribed to derangement of the tissues beneath; but in opposition to this assumption, I would adduce the facts that in Sydney there was almost complete absence of coryza, yet the pains in the superciliary ridges and nasal tuberosity were just as intense as they were reported to have been in Europe. Hence, here we had pain without indication of catarrhal metamorphosis, and in Europe they had pain together with catarrh, but not necessarily, I maintain, dependent upon that state of the mucus membrane. Furthermore, there was pain in the upper dorsal regions, but no one declared that it indicated pleuritis of the posterior pleural sac, and the argument is as feebly applied to one region as to another.

However, reverting to the text of the paper, conjunctival suffusion was common, but there was no oedema or puffiness of the face.

The temperature varied between 100 and 102.5, and rarely exceeded this, attaining a maximum under 24 hours, and falling rapidly to normal or subnormal in about 48 hours. I had no case of well marked rigors, but two in which influenza was ushered in by convulsions. It is almost needless to say that these occurred in children.

The pulse was small, rapid, and very weak, its rate ranged between 100 and 130.

The skin at first was dry and simulated the burning feeling so general in scarlet fever. One or two instances exhibited a slight papular rash, which did not terminate in desquamation.

The patients laboured more or less under mental depression.

The functions of the organ of special sense did not seem to be specially interfered with. I had one exception, however, in which the powers of the left auditory nerve fell into abeyance, but they have now resumed their wonted vigor.

In those who had epistaxis it continued for three or four days.

Vomiting and purging, when present, were early symptoms of about 24 hours' duration. I had no case of persistent gastro-intestinal irritation.

In the thorax the heart in one instance developed a transient bruit. In the lungs, ephemeral sibilant and sonorous rales could usually be detected. In only two cases did the

pulmonary bases show congestion. In fact, the lesions of the air passages, which are such a frequent cause of mortality in Europe, were extremely mild, and the absence of these complications doubtlessly enabled the colony to show an almost clean mortality table, for I can only discover five recorded deaths from influenza in N.S. Wales.

With the exception of the temporary presence of polyuria, or febrile urine, there were no indications to denote deviations from the normal renal excretion, or to imply that any structural changes had ensued in the kidneys.

Relapse.—About eight or nine days subsequent to invasion a relapse may supervene, accompanied by practically the same symptoms as those of the primary disorder; and although I have not had occasion to treat a relapse when a doctor had been in attendance at the first onset, yet my worst cases were those of relapse, the initial disease having been combated by treatment at the hands of non-professional people. As far as I can judge the relapse was coincident with the incursion of wet and cold weather, yet what relationship they bear to each other is matter for further observation.

Convalescence.—Restoration to health was accompanied by decided anæmia and pallid countenance, together with debility and weakness out of all proportion to the brief duration of illness.

Differential Diagnosis.—The sudden invasion, high temperature, short duration of grave symptoms, extreme prostration and occasional relapse are sufficiently characteristic to differentiate influenza from other ailments. I certainly fail to recognize any sound basis which could lead me to confound influenza with any other affection. It seems that the body becoming infected the brunt of attack may fall upon almost any part or organ, and the local manifestations simply reveal the area most involved.

Treatment.—Probably medical opinions differ more on this point than on any other, and each doctor has his own pet remedy which, in the way he applies it, enhancing its virtues by utilizing various minor adjuncts in support of the prime drug, yields him very good results; and by no means does it follow that a medicine is of little value because it was found deficient in the practice of some other prescriber. Esculapius requires various propitiations according to the vagaries of his votaries. My own peace-offerings were tendered with opium, salines, antipyrin and its congeners, and finally the sacrifices lapsed into salicylate of soda with bicarbonate of potash and compound gentian tincture. With each periodical immolation of this mixture a proportionate quantity of brandy was given, and I believe my best results were attained in this manner.

The debility was more amenable to strychnia than to any other drug.

Corollary.—I think it must be conceded that Australian influenza is the same old-fashioned disease which has been recognized as influenza for ages, and that it does not differ in any respect from that which we all expected to see amongst us, notwithstanding the garrulations and hysterical ejaculations of cablegrams and sensation writers on newspaper staffs; and if such be admitted it becomes a duty to protest against the misnomer of *Russian* influenza, as the term conveys to the vulgar mind a belief in some mystic or new disorder, and inferentially assumes that doctors are ignorant of a very definite, distinctive and ancient complaint. The fact that the epidemic was first noted in Russia during the cold and damp of autumn—a season, by the way, highly suitable to aggravate any implication of the respiratory track and cause augmented death-rate—has endowed the popular mind with the sophistry that another plague has been unearthed to the consternation and dismay of medical men, who had no idea such a disease existed. As the surroundings and peculiarities of districts vary so one might expect modifications in the symptoms and progress of the disorder, and such is found to be the case, yet it still remains the same disease. Therefore the adjective *Russian* ought to be expunged from even conversational nomenclature, and if it be necessary to denote severity in an attack surely one can express a grave opinion in suitable terms without fostering a deception in the popular mind. For such is the tendency of ill-advised comments embraced by the term *Russian* influenza.

Finally, in enumerating the foregoing symptoms I have simply culled from my case book, and hence many of the particulars will fail to coincide with the experience of members of the faculty taking part in the present discussion.

The PRESIDENT said he would be glad to hear the experience of any of the members present in regard to the disease.

DR. CRAGO said that he had come last month prepared with notes, which he had not at present with him, but would relate his experience, which had extended to about 116 cases, from the beginning of the epidemic. He had treated the first case about the 30th March last. He did not think he could throw much new light upon the subject. The earlier cases which he had treated partook of the febrile or nervous forms. From the *International Journal* he observed that a writer had collected opinions from gentlemen in Berlin, Vienna, and elsewhere, and they spoke of three forms of the disease—classified as the nervous form, the febrile form, and the catarrhal form. His earlier cases comprised the nervous and febrile forms, some lasting 24 hours and others 72 hours. The patients were affected with an intense frontal headache, pains in the back of the neck and limbs. He had three cases

in which there were severe pains inside, which it was at first thought were the result of pleurisy. As the epidemic wore on he found cases of the catarrhal form, which lasted longer than the simple and febrile attacks. Of the alimentary form he had many cases, and might quote that of a policeman, a very strong man, who was taken so ill that he had to be carried home, his temperature reaching 103°. Later on it was 105·6 or 105·8°. It came down, however, 6 degrees in the next 24 hours, and on the following morning fell to 101·6°. In many of the cases there was effusion of the eyeballs, and an aching pain at the back of the eyes. In two cases hæmoptysis appeared, not severe, but sufficient to induce the patient to seek medical attendance, and, in one case, a distinct rash had manifested itself. The earlier cases he had treated with quinine, and found that on the second day the temperature had become normal. He had administered 1 grain, which appeared to give immediate relief to the headache. The catarrhal form of the disease he had found more difficult to treat. With regard to relapses, he might mention that his wife had had three attacks. One week she had had intense pains all over her body, and the following week had another attack, her temperature running to about 102°. On the third occasion she had become affected with a very irritating cough. When he sent in his return to the Board of Health he had stated that the patients were generally convalescent in three days. His experience, however, had since been different in this respect.

DR. CHISHOLM stated that he was away from home when the influenza epidemic broke out, and he had had but few cases, which were similar to those referred to by Dr. Skirving. It struck him (Dr. Chisholm) as a matter for remark that in England the great distress seemed to fall upon the respiratory organs. Dr. Skirving had said that there was rheumatism in one of his cases. He (Dr. Chisholm) had seen a girl 15 years of age who, though perfectly well the day before, had a temperature of 104° or 105°. She had a swelling of the knee and one ankle. He had put her under sal. of soda, and she recovered in three days. In this case the girl was suffering from rheumatism. Concerning cases in hospital, Dr. Whittell, of Adelaide, had given an account in which he had drawn attention to the fact that in two-thirds of the cases the patients themselves were not attacked, the disease thus predominating among the nurses. Probably this could be accounted for by the fact that the patients were kept warm, while the nurses were exposed. With regard to the efficacy of drugs he thought very little was required, unless in cases of constipation. The patients should be kept warm in bed and given some diuretic mixture.

DR. JENKINS observed that there were many members present who had, no doubt, suffered from influenza themselves. He himself had had an attack which was accompanied by a severe headache. His temperature was 104·3°, afterwards falling to 104·2°. In this disease there was a comparative immunity in children. He had treated 23 cases in private practice, and not one of these cases was that of a child. Concerning drugs he might say he got considerable relief from the use of antipyrin.

DR. RENNIE said that the use of antipyrin afforded great relief to the headache, and had noticed a record in the *British Medical Journal* of the cases treated by this drug.

DR. FAITHFULL had seen a number of cases similar to those already described. The treatment he had pursued was to prescribe sal. of soda, and most of the patients were well in 24 to 60 hours. He did not use

antipyrin in any case. With children he had insisted that a hot-water bottle be kept to the feet. He had had the attack himself very severely, accompanied by pains in the head.

DR. POCKLEY touched upon the question of the infectiousness or otherwise of the disease. He said it was supposed not to be infectious. In his experience of 30 cases he had not met with more than one in the same family, and he had not seen a single case among children under four years of age. In Randwick Asylum there were many cases, but they ran a mild, short course. He knew a middle-aged lady who treated herself for an attack of influenza. She had a relapse, however, and her daughter insisted upon sleeping in the same bed. The first daughter who slept with her had a well-marked attack. Next night a second daughter who slept with her met with the same result. The husband of the daughter also became affected, while a daughter who did not sleep with the mother escaped the disease. He considered that these facts were proof as to the infectiousness of the disease, and also threw some light upon the incubation period.

DR. FIASCHI said that the object of the discussion was as far as possible to fix the nature of the disease from the facts related at the meeting as well as from those quoted in reference to other countries. We had now evidence to show that the disease was infectious beyond doubt, and it was shown that the disease affected individuals in different ways. Some had a predominance of the nervous form, others had affection of the lungs, while others had affection of the stomach. These were three great classes under which the disease had been classified. It appeared to affect individuals according to the qualifications of their organs, which in some were stronger than in others—indeed all the different symptoms, or classes of symptoms, were qualified in different individual cases. It was not necessary to go into detail, but he might mention that the epigastric functions were more or less affected by the disease.

DR. McDONAGH remarked that five years ago an epidemic broke out which was then known as spurious influenza. He found that in many points it bore resemblance to dengue fever. The epidemic, which would, probably, be remembered by many of those present, passed off more rapidly than the recent one. In influenza he found that extreme prostration took place, that there was great liability to relapse, and these relapses were more intense than the preceding disease. He, himself, had suffered three relapses of the disease. The temperature, he found, ran to about 103° or 104°. Concerning incubation his experience was that it occupied from two to three days, and he found it decidedly infectious. He had met with five distinct cases of roseola desquamation, had been accompanied by extra itching, which, however, passed off. In reference to treatment 10gr. of Dover's powder had been found to act like magic, causing disappearance in one day of all catarrhal symptoms. Citrate of potash and tart. of iron had also been found efficacious. One case he had attended was so severe that he thought it was cholera, the patient being in a state of collapse, and having diarrhoea and vomiting. It had been mentioned in the *British Medical Journal* that most of the deaths occurring in England might be put down to the use of antipyrin. In a discussion such as the one going on, in which symptoms of the disease described, and the experience of individuals rather similar, it would assume a more changeable form if the causes were inquired into. As to the use of the term "Russian" in connection with the disease he regarded it as nonsense. It was merely typical with dengue or very acute catarrhal fever.

THE PRESIDENT said his experience was small. As regarded infectiousness he knew of one case where a relative caught it through nursing an aunt. The first case he had seen reminded him forcibly of a case of small pox. There was severe pain, nervous depression, and irritability of the skin. The patient, he might mention, had touched a dead Chinaman, and thought the disease arose from the poisonous microbes usually emanating from a dead body.

DR. MARANO said that though he had not seen many cases of epidemic influenza, yet from those he had seen and from what he had read about the disease as observed by others, he was of opinion that the chief characteristic of influenza was Neuroses of the pneumogastric nerve. It was not possible for him then to go minutely into the matter, yet if they would call to mind the symptoms that were present in all cases of La Grippe, it would be seen that the functions of the pneumogastric nerve were always affected, with a prevalence of broncho-pulmonary symptoms in one set of cases, of cardiac symptoms in another set, and of gastric symptoms in the smallest number of all. The mode of development of the symptoms in broncho-pulmonary cases gave the impression as if the pneumogastric nerves had been cut (suddenness of invasion, extreme weakness, passive broncho-pulmonary congestions, and all the cardiac symptoms), and therefore not to be attributed to infective myocarditis, which instead, like genuine pneumonia, was comparatively rare. Lastly, the extreme prostration of strength and absolute anorexia, &c., which characterized some cases, was more suggestive of a parietic state of the nerves aforesaid than of ordinary gastric affections.

DR. SYDNEY JONES wished to know if any members had observed that peculiar form of influenza called Nona. It was characterized by a state of unconsciousness lasting two or three days. He should like to be advised if any members saw any cases in which anything like that condition existed. His experience of the epidemic had been small, altogether he thought about ten cases, these being mostly confined to members of his own family. It appeared to him that there were two forms of the disease, the nervous or typhoid form and the catarrhal form. So far as he had observed, the present epidemic had been distinct from previous epidemics, owing to the greater number of nervous cases. In these nervous cases there was an entire absence of coryza or catarrh; in others, after the acute nervous symptoms had subsided, then the catarrhal symptoms showed themselves. He observed that in some cases where the original attack had been of the nervous character, the relapse was of a distinctly catarrhal nature. There was sneezing, coughing, and the bronchial disturbance familiar to all present. In one or two cases he had seen a rash, which appeared to be the ordinary roseola. He was rather suspicious that in many cases in which rash had been observed it was due to the use of drugs and not to the disease. Rose rash had been observed frequently in cases in which antipyrin had been administered. He must confess that although antipyrin was popular he was timid in administering it. The reference made by Dr. McDonagh to the effect of antipyrin, as recorded in *The British Medical Journal*, confirmed his (Dr. Jones's) suspicion as to the propriety of administering the drug. The use of salicylate of soda appeared to relieve the intense headache and backache which characterized most of the cases. In one case of a child of his own the disease was ushered in by a convulsive seizure; another characteristic of the epidemic was the extreme debility which followed, the acute symptoms lasting in some cases as long as three weeks. As far as his

recollection served, in previous cases of influenza that extreme depression and weakness did not prevail to anything like the same extent as it had done in the last cases.

DR. Worrall said in reference to the effect on menstruation, that the disease prevailed very extensively amongst the gynaecological cases attending the outdoor department of the Sydney Hospital, but it presented no special features, nor did it seem to exercise any marked alteration in the various symptoms from which the patients were suffering.

DR. HODGSON, in reply, observed that it was the contention of Dr. Marano and Dr. Crago that the disease fell upon any part of the body or organs, and that it was to be divided into three classes. It could scarcely be decided, however, why it should be split up into three classes. It might affect one part more than another. Concerning catarrhal symptoms, he might mention that there was an entire absence of these in the form of influenza appearing in Sydney.

DR. KNAGGS, in reading the following notes on a case of fracture of the lower jaw and exhibiting cast of same, remarked that the matter was a simple fracture set in a simple way, and the facts in connection therewith were he thought of some importance as a nice question of medical ethics. He would first read the notes:

CASE OF FRACTURE OF JAW IN A LAD TREATED BY AN INTER- DENTAL SPLINT.

By SAMUEL T. KNAGGS, M.D., F.R.C.S.I.

E. G., a lad *æt.* 5½ years, on Friday, 4th April (Good Friday) was kicked by a horse in the mouth. Saw the case on 12th April, eight days after the accident, when there was much displacement of a fracture through the symphysis of lower jaw, the left central incisor was absent—its socket being in the seat of fracture. The right side of the jaw was upon a plane below and behind the left side, the line of fracture extending in a line obliquely downwards and to the right. The upper jaw was also much injured, the right canine and all the incisors having disappeared as well as the alveolar process. This is admirably shewn in the model that I have now before me. The boy was most nervous, excitable, and as far as any examination of the fracture was concerned he was impracticable. It at once occurred to me that any examination or manipulation must be done while the patient was under an anæsthetic; also that the best and most appropriate treatment would be by the use of an interdental splint, with which view I availed myself of the assistance of my friend Dr. Burne, the well-known dentist, of No. 1 Lyons' Terrace, to whose skilful manipulation and construction of models are due the successful issue of this case. He kindly took a cast of the upper and lower jaws—the patient being under an anæsthetic—from which casts he made models shewing the

fracture and deformity *in situ*. Then taking the model of the fractured lower jaw, the seat of the fracture was carefully sawn through, and by means of cement the deformity of the model was readjusted and fixed in the normal position.

The readjusted model of the fracture of the lower jaw and the model of the mutilated upper jaw were placed in a hinged apparatus, called by dentists a masticator, and by means of this appliance a gutta-percha interdental splint was formed, with depressions in it above and below, into which fitted the teeth of the lower jaw of the model and model of the mutilated upper jaw. In this interdental splint there was left a slot through which the patient could take food.

These preliminaries being arranged, the patient was again placed under the influence of an anæsthetic—the upper jaw fixed into the upper sockets of the splint, and then by manipulation the fracture was set, so that the lower teeth fitted into the sockets made for them in the lower surface of the splint. The lower jaw was then firmly secured by means of a gutta-percha splint, modelled below the chin, and firmly secured in position by bandages carried above and behind the head. No difficulty whatever was experienced in feeding the child with slop food, which he could readily suck through the oblong opening in the splint.

The fracture was left thus for four-and-a-half weeks, and on the 14th May removed. Saw child 1st July, and found fracture had been set in excellent position.

QUESTION OF ETHICS.—With regard to this question of ethics there was no man more unwilling to raise unpleasant feelings among his brother practitioners than himself. A man had brought the child into his consulting rooms saying that its jaw had been set by another medical man, but he desired him (Dr. Knaggs) to take up the case, urging objections to the medical man attending further to the case, and also refusing to allow a consultation. He (Dr. Knaggs) would like to have the opinion of some of the older members of the profession on the question of medical etiquette.

DR. NEWMARCH thought that Dr. Knaggs was to be congratulated on the way the jaw had been set up, as there was scarcely anything more difficult to manage than a fracture in a child's jaw. This was his experience, and of all the methods he had used he had found the wire the most successful. It would have been interesting, he thought, to have seen the child with the splint fixed into its mouth. As to the question of ethics, he considered that Dr. Knaggs' action was quite correct in taking the case, providing he found that the other medical gentlemen had been paid his fee, as it might have been a ground for taking the child away from a practitioner who was capable of treating the case simply because fees were owing to him. This frequently occurred.

DR. FIASCHI desired to know whether it was necessary to draw the teeth to feed the child.

DR. KNAGGS replied that the splint was so wide that there was sufficient opening without drawing the teeth.

DR. FIASCHI thought Dr. Knaggs' action justifiable on the question of medical ethics. The medical gentleman had an opportunity of meeting Dr. Knaggs, and —

DR. KNAGGS: He had not that opportunity. The parents of the child would not let him.

DR. FIASCHI said, apart from this aspect of the question, Dr. Knaggs' action was quite justifiable.

DR. READING did not know whether the case was one which he saw. On last Good Friday a child was brought to him which had been kicked by a horse. The little one was about 5 years of age. All the upper incisors were knocked out, and there was a fracture in the lower jaw. The woman who accompanied the child said she had been sent by a medical man to see if any teeth should be taken out. From her statement, he gathered that she had not been sent to have the child treated for fracture of the lower jaw; he, however, told her to take the child back, and if he was really desired to treat it for fracture of the jaw he was willing to do so. He did not see anything more of the case, which seemed to be identical with the one mentioned by Dr. Knaggs, who, he thought, was quite right in treating the case.

DR. CHISHOLM considered, with the other speakers, that Dr. Knaggs had acted correctly. Patients had a right to consult whom they liked, and doctors had no proprietary rights in this respect. If he were ill, he considered he had freedom to consult whatever doctor he pleased. At the same time, he admitted any medical man attending a case should not be superseded without some just cause. A patient should write a courteous note, saying he did not require him any longer. Patients, however, were not always the best judges, and sometimes changed their medical men without just cause. He mentioned that there was a gentleman in Sydney who went alternately to himself and to a medical friend, running up an account with each, and thus bestowing the patronage alternately.

DR. SYDNEY JONES agreed with patients having rights as well as doctors. Supposing that Dr. Knaggs had declined to attend the boy, and supposing all the medical men to whom the parents had taken the child also refused, the child might have been hawked all over the town, which would have been a gross act of inhumanity. Dr. Knaggs had done all he could—he had ascertained from the parents that they had written a courteous note to the medical man, and that they had declined to leave the child under his care any longer. He thought the action of Dr. Knaggs right and proper in every sense of the word.

DR. GOODE said that he had used the splint referred to in a case where the fracture was near the angle of the jaw. It seemed to be excellent for a fracture near the synpos, but for a fracture lower down it could not be used with such advantage. He thought there was no other course open than for Dr. Knaggs to take the case.

DR. CHISHOLM entirely agreed with the previous speakers upon the question of etiquette, and considered that Dr. Knaggs had nothing to reproach himself with. He would like to know whether the splint was removed, or was it at all offensive, getting it into the mouth.

DR. KNAGGS, in reply, said it was a great relief to his mind to hear such favourable criticisms. He certainly had some qualms, which were greatly increased when another medical man came to his rooms and expressed his opinion that it was a great breach of etiquette to take up the case. Concerning Dr. Chisholm's question he might say that he left the splint in the whole time. To avoid offensiveness the child's mouth was washed out.

EXHIBIT.

DR. GRAHAM exhibited a tumour showing hydatid of the liver, remarking that it was of interest as showing that the cysts were surrounded by three inches of liver tissue, and death had occurred from simple puncture. There would have been a difficulty and danger had an attempt been made to operate by cutting through the liver substance before reaching the cysts. The shape of the liver seemed to be uniform. It was evidently hydatid. A needle was inserted into a prominent portion, and nothing got out but blood. Half-an-hour afterwards the patient was breathless, broke out in copious sweat, and was apparently *in extremis*. Brandy afforded temporary relief, but he shortly afterwards died. The needle-tracks were visible subsequently. There was no trace of peritonitis. The question arose—what was the cause of death? Was it due to shock? Death had occasionally followed from this cause. Many fatal cases had also occurred through puncture of hydatid liver. In many instances where there were no fatal results, the patients suffered a series of distressing symptoms—severe pains, rapid pulse, and a general condition of distress. The theory had been ventured that the serious trouble arising from extravasated fluid was due to the absorption of the fluid itself. Certainly the experiments carried on seemed to favour this view. The series of experiments of M. Roy, as noted in *The Lancet* three years ago, showed that quantities of hydatid fluid had been injected into dogs with fatal results. The question which it was desirable to settle was whether one was justified in inserting a needle for the purpose of exploration.

DR. HODGSON asked how much fluid was in the cavity.

DR. GRAHAM: About half-a-pint.

DR. JONES said the question of the preliminary treatment of hydatid disease was one of the utmost importance. At the Congress in Melbourne the question was raised, and a considerable section of the members present were strongly in favour of incision and drainage in all cases of abdominal hydatids. He favoured the theory of simple tapping or aspiration. The Adelaide School would ask us to believe that aspiration was more dangerous than incision and drainage. In all cases of the kind under discussion fatal results were brought about by the use of a needle far too large. To get good results from simple tapping it was necessary to use a fine needle. Dr. Graham had remarked that the needle track was visible at the *post mortem*. That convinced him (Dr. Jones) that the needle must have been of considerable size. A needle could be inserted freely into the liver, and still leave no sign or track when the *post mortem* was made. He intended before the next congress to insert an advertisement in the *A. M. Gazette* asking his brother professionals for a list of cases showing the remote result of aspiratory treatment which had come within their experience. That would be a valuable contribution to a question which needed settlement. There was a great divergence of opinion upon the treatment of hydatids, and anything that would lead to a uniformity of opinion would be of great advantage.

DR. WORRALL remarked that thanks were due to Dr. Graham in bringing forward this case, which illustrated the dangers of aspiration in hydatid disease. He (Dr. Worrall) had seen the dangers of aspiration when puncturing any cyst during abdominal section. He had noticed that when the canula was withdrawn there was invariably a drop of fluid to be seen following, and if a sponge were not handy, or a forceps ready to catch up the receding point, there was the certainty of the fluid trickling into the peritoneal cavity,

which would probably cause shock and other serious symptoms. The only criticism he desired to make was, that he believed that in the case under discussion, if the peritoneal cavity had been opened and washed out when the serious symptoms occurred, the result might have been different.

DR. GRAHAM, in reply, observed that we should look forward with pleasure to the researches of Dr. Jones. He (Dr. Graham) was not at all satisfied that his patient did die of shock. This was an important point, and if such were the fact, then mere tapping of the hydatid cyst was an important matter. He did not think the size of the needle affected the case, as the needle was a small exploratory size. The track could be noticed. Shock was not sufficient to account for the deaths recorded of these cases. In his opinion aspiration of hydatid tumour of the liver was an unscientific method. There were some men to be found who would advocate the treatment of ovarian tumour by aspiration, and there was no doubt that aspiration had cured cases of hydatid tumour. The Adelaide men, in the 500 cases they had got together, quoted 50 per cent. as successful, and he considered that treatment which did not give more than 50 per cent. of cures was highly unsatisfactory.

MEDICAL SECTION OF THE ROYAL SOCIETY OF NEW SOUTH WALES.

THE ordinary monthly meeting of the above Society was held at the Society's Rooms, Elizabeth-street, Sydney, on Friday evening, July 18th, 1890, at 8.15 p.m. Present:—Professor Anderson Stuart (in the chair), Drs. Fiaschi, McLaurin, Knaggs, Sydney Jones, Crago, Quaife, Megginson, Milford, Scot-Skirving, Newmarch, Hankins, Chisholm, Clubbe, Worrall, Mullins, Graham, McCulloch, O'Reilly, Shewen, Fieldstad, West, Martin, Professor Wilson and the Honorary Secretaries. Visitors: Dr. Shand (Perth) and Struthers.

Professor WILSON exhibited and described for Dr. MacCormick a case of malignant disease of the neck, in which an operation had been performed, the result of which was to leave an opening in the side of the pharynx through which the movements of the epiglottis during deglutition could be observed. It was manifest that in this case the epiglottis did not cover the upper opening of the larynx during the act of swallowing, but maintained an erect position, notwithstanding the fact that the muscles acting on the epiglottis had not been interfered with. The patient experienced no difficulty during deglutition, and considered that he performed the act naturally. In the opinion of the meeting the case shewed that the generally accepted view that the epiglottis is drawn over the upper opening of the larynx during deglutition is open to doubt.

The CHAIRMAN then called upon Dr. Fiaschi to open a discussion on "The Operative Treatment of Hydatid Cysts." Dr. FIASCHI then read the following paper:—

ON THE SURGICAL TREATMENT OF INTRA-CRANIAL HYDATIDS.

By THOMAS FIASCHI, M.D., CH.D., PISA AND FLORENCE.

At the request of our learned President, Professor Stuart, I have the honour to bring under your notice to-night, for discussion,

the practical aspects of the surgery of intra-cranial hydatids. The case shown at our last meeting of a lad who for some time had presented various symptoms of progressive compression of portions of the brain, diagnosed by Dr. Graham as due to the presence of a hydatid cyst, and by Dr. Clubbe successfully operated and well now, has vividly impressed us with the importance of such an operation, and of the possibilities opened up to us for saving life. This case, the first as regards successful result, is second on the list of recorded ones as regards conception; for Dr. Verco, of Adelaide, on the 30th November, 1888, operated on a boy 10 years old for a very large hydatid cyst, full of daughter cysts, nestled in the right hemisphere, in a cavity of 16 inches capacity, and encroaching forward in the frontal, upwards in the parietal, and backwards in the temporo-sphenoidal lobes. The boy lived for four days after the operation, and died of meningitis.* These two cases, and the recent progress of surgery of the brain, urge us on to operative measures in the treatment of intra-cranial hydatids. Hitherto the natural course of such cases was a steady progress towards death. Only in extremely rare instances do we find an effort of nature towards bringing about a spontaneous cure. I may quote as such the following case, read by Mr. Lupton at a meeting of the Midland Medical Society, on the 1st April, 1885,† of a girl aged 13, who for twelve months had a swelling on the head, discharging pus, subsiding and again filling up repeatedly. There was an aperture through the skull, just large enough to admit the tip of the little finger, and on the withdrawal of this it was followed by an ounce or two of hydatid fluid and about a dozen of hydatid cysts. The cavity was washed and drained, and ultimately the girl recovered completely.

The treatment of brain hydatids, up to the present, has been merely palliative, strongly contrasting in its fatal record with the good results obtained in the treatment of hydatids of other organs. This is all the more to be regretted, inasmuch that hydatids of the brain are by no means unfrequent. In the very complete table of cases collected by Dr. Davies Thomas from European, Australasian, American and Indian sources,‡ the brain comes fourth in the order of organs affected by hydatids. First comes the liver, second, the lungs, third, the kidneys, fourth, the brain. On the total number of cases, the brain has a percentage of 4·3; and in proportion to other organs

we find, putting it roughly, one case in the brain to thirteen in the liver, to three in the lungs, and to one and a fraction in the kidneys.

Now then, that the road to surgical treatment of intra-cranial hydatids has been opened for us, what amount of success can we expect by it, and how far will the rules laid down for the localization and removal of other cerebral growths assist us? To the first query our experience, though limited to only two cases, gives us good ground to reply. In studying these we are struck by the size of the cysts. Both were of a capacity of no less than 16 inches, causing enormous compression of the brain as a whole, and considerable thinning and loss of brain tissue. As a result, we find that the successful case of Dr. Graham, although indisputedly so far as life and recovery of motor power are concerned, is as yet totally blind. We can infer that the largeness of the cyst not only increases the risks of an operation, but causes permanent loss of function, and our measure of success for the future will depend from our ability to stop the cysts from becoming too large. Just as surgery of the brain has influenced the treatment of intra-cranial hydatid cysts, it will come in time, at least for Australia, that treatment of intra-cranial hydatids will influence and modify the rules given to surgery of the brain, in the sense of encouraging early interference.

I am sorry not to be able to give to you the exact proportion of hydatids to other growths in the brain, as found in European or American statistics. Did I have them they would be an imperfect guide for us, on account of the greater prevalence of hydatids here. It is a work, however, that requires doing, and I trust that some of the gentlemen here present, having access to the statistics of hospitals in this colony, will do it for us. By analogy with other organs, where even the most prudent surgeons have at times found that in operating a tumour diagnosed for some other growth, it has turned out to be the ubiquitous hydatid, we can safely infer that a very large proportion of cases presenting symptoms of progressive compression of the brain, and in no way due to the results of injury, hæmorrhage or pus, or to a syphiloma, are hydatid cysts. In these cases then, how do the rules laid out for the localization and removal of cerebral growths assist us? As to the first I would say—well, judging from the records of the two operated cases and of the numerous cases of cerebral hydatids diagnosed and localized during life, and verified after death—my only hesitation in stating this absolutely is on account of the opinion expressed by such an eminent pathologist as Mr. Bland Sutton, “that in sheep hydatid cysts of the brain are common, but that it is not possible to

*Transactions of the Intercolonial Medical Congress, Melbourne, 1889, page 377.

†British Medical Journal 2nd May, 1885, page 397.

‡J. Davies Thomas, Hydatid Diseases, Adelaide, 1884, page 124.

localize their position from the symptoms." *

The reason of such an opinion may be that hydatid cysts, not absolutely destroying brain tissue as some of the neoplasms do, the amount of function lost is not proportionate to the extent of brain tissue on which the cyst encroaches; and also that from their very coarseness we cannot expect to have symptoms for exact localization of a scholastic exactitude.

Coming now to the rules laid down by experienced men as to when to operate cerebral growths I will say that had Dr. Verco and Dr. Graham observed these strictly we would never have received the benefit of their cases. The moving spirit of these rules has been to restrain surgeons from interfering in cases of large growths. These are, as a rule, gliomata, which, besides their malignancy, extend by infiltration and by destruction of the brain substance. It is clear that an attempt to remove a large growth of this kind would be followed by no honour to surgery. Hydatids instead, whilst having a tendency to attain just as large a size, push away and compress the brain substance, which does not lose its capability to recover function until atrophy sets in as a result of prolonged compression. Taking then into account these facts our rules for interference in cerebral growths will require for the future greater amplitude. Certain restrictions, such as not to interfere whenever paralysis of one or more cranial nerve or neuro-retinitis or other symptoms of basal lesion are present, will have to be overlooked when we think that we are dealing with an hydatid cyst.

How can we make sure that it is a hydatid in the case of a large cyst, so as to avoid cutting on an unpromising glioma; on the other hand by what means can we gain confidence to operate in the case of a small one, so as to carry out our resolution of interfering early to prevent permanent loss of function. I think there is an easy way to acquire this certainty, if we will but follow the plan pointed out to us by Professor Souchon, of New Orleans.† According to his experiments the brain may be explored with a fine aspirating needle, introduced through a small hole made in the skull with a watchmaker's drill, furnished with a gauge and screw so adjusted as to prevent the "bit" from penetrating too deeply after working through the bone. He has performed the operation several times on dogs, and these animals after recovering from the chloroform did not seem to have been in any way affected by the operation, and remained afterwards in perfect health. In an animal killed before recovering from chloroform

there were seen only small extravasations under the scalp and under the pia mater.

Professor Souchon thinks that the "bit" used should be large enough to make a hole in the skull to admit a needle twice the size of an ordinary hypodermic needle. Why then not use for the brain aspiration by the hypodermic syringe as an exploratory measure, in the same way that we have done, and with so much advantage, in hydatids of the lungs? The gauge and screw preventing the bit from penetrating too far, and and a little judgment in the selection of the place for puncture, ought in the greater part of cases to save us from drawing fluid from a dilated ventricle. Should that happen the chemical testing of the drawn fluid, on the spot, should in the greater number of cases, enable us to differentiate between the two liquids.

We have as yet considered the question of intra-cranial hydatids as primary, but it may happen that on testing a patient for hydatids either in the abdomen or in the chest, we may see cerebral symptoms set in, or follow some time after. I have twice seen such an occurrence in consultation, and the cerebral cyst was allowed to run on to its end; but both these cases happened several years ago, when as regards cerebral hydatids we were yet in the præ-chirurgical stage. I would now consider it my duty to deal surgically with the hydatids in both localities, one after the other, giving priority to the most urgent. I would come to such a resolution fully estimating the extreme gravity of such cases, but the opprobrium of those diseases against which we are powerless weighs too heavily on us to allow us to lose any chance in a disease like hydatids, whose nature is perfectly clear to our understanding and against which we can successfully cope. You will all agree with me that our motto in the treatment of hydatids should be *guerre a outrance*.

Where difference is more likely to arise is in regard to treatment. Given that we have localized and made sure of the presence of a hydatid cyst in the brain by drill and hypodermic puncture, what is the best form of treatment? Must we trephine, empty out and drain, or merely be satisfied with aspiration? With the scarcity of material possessed any strong statement towards either course would be wrong, for future experience might yet prove the other method the best. For the present I would certainly give the preference to trephining, section and drainage under strict asepsis.

Drs. Milford, Sydney Jones, Worrall, Graham and Shewen having spoken on the subject future discussion was, on the motion of Dr. Scot-Skirving, adjourned until the next meeting.

* *The British Medical Journal*, November 10, 1888, page 1046.

† *British Medical Journal*, 1st June, 1889, page 1248.

THE WESTERN MEDICAL ASSOCIATION OF SYDNEY.

THE Association is steadily progressing, and its influence is now much felt in the districts embraced by it, and it is hoped that, before long, these districts will be added to. It is noteworthy that, on the Glebe, a member of the Association has been successful in raising his fees in three lodges from sixteen shillings (16s.) to one pound per member per annum.

The Council of the Association have to acknowledge the cordial support accorded by several members of the profession, not members of the Association, who were candidates for one of the appointments. Two gentlemen voluntarily withdrew when the facts were pointed out to them, and two of the applicants promised to raise their tenders to the minimum fixed by the Association. Such support is very gratifying, and the result plainly shows that medical men, by supporting one another, can easily attain the objects for which the Association is working.

A still more notable result of the working of the Association is that one gentleman, though not being a member, has lost one, if not two, of his lodges. The members, considering it an advantage to have a doctor who is a member, declined to elect one who is not a member. This fact speaks for itself.

Thirty-six new honorary members residing in Sydney, the suburbs and country districts, have been elected since last report.

SOUTH AUSTRALIAN BRANCH OF THE BRITISH MEDICAL ASSOCIATION.

MONTHLY meeting held at the Adelaide Hospital on the evening of July 24, 1890. Present: Dr. J. A. G. Hamilton, President (in the chair); Drs. T. K. Hamilton, Clindening, Cawley, Perks, Swift, Bickle, Symons, Hayward, Singleton, Cleland, London, Jay, Cookson, Stewart, Corbin, Professor Watson and the Hon. Sec., Dr. Poulton.

The minutes of the annual meeting were read and confirmed.

EXHIBITS BY PROFESSOR WATSON.

(1) The ileum of a man, *æt.* 21, who died of non-leukaemic lymphadenoma, or Hodgkins' disease. Both the solitary follicles and those aggregated in Peyer's patches were the seat of a very marked hyperplasia, producing an analogous condition to that found in earlier stages of typhoid fever. Pressure on portal vein by masses of enlarged lymphatic glands (in relation with the pancreas) and pressure on external iliac veins from a like cause had produced a marked cedema of lower extremities and ascites.

(2) *Ascending and transverse* colon of a girl, *æt.* 17, who died on the seventeenth day of hæmorrhagic typhoid. There were numerous circular ulcers with raised hæmorrhagic edges throughout the large intestine, quite throwing into the background some less marked changes in the Peyer's patches—the usual seat of such in the small intestine. Countless petechia of the skin (principally of breast and abdomen) and several pulmonary hæmorrhages and multiple ecchymosis of pleura and pericardium, &c., were found at the necropsy.

(3) Uterus of a woman, *æt.* 54, who died, 10 days after removal of the right breast and axillary glands, of thrombosis of pulmonary arteries. Growing from the cervix uteri was a crop of pedunculated adenoid growths, which protruded through the os into upper part of vagina.

DR. T. K. HAMILTON showed a larynx with a tumour growing from the posterior commissure.

FRANCIS WILLIAM COUNTER, M.B., C.M. (Aberdeen), residing at Willunga, and EDWARD WALTER MORRIS, L.R.C.P., M.R.C.S., L.S.A., residing at Port Adelaide, were elected members of the British Medical Association and its South Australian Branch.

The following papers were read:—

ON PLEURISY AND PLEURITIC EFFUSION, WITH SPECIAL REFERENCE TO TREATMENT.

By J. C. VERCO, M.D. (LOND.), F.R.C.S., &c.,
LECTURER ON MEDICINE, ADELAIDE UNIVERSITY,
PHYSICIAN TO ADELAIDE HOSPITAL.

In accordance with the expressed wish of the Council, I have prepared a short paper on Pleurisy and Pleuritic Effusions, so as to inaugurate a discussion on the subject. I feel some diffidence, because I have to follow Dr. Hayward, and not knowing exactly the course which he will pursue, I am very likely to cover the same ground, and thus unnecessarily occupy valuable time. However, I so thoroughly coincide with the desire of the Council to establish fairly complete investigations of set subjects, that I will cheerfully do my best to use the little material at my command and indicate the teachings of what experience I have had.

Although the title of the paper opens the whole subject of Pleurisy for our remarks, yet it indicates—and I think wisely—that these should be limited to the circumstances which, more or less, directly bear on the question of treatment. And in this narrow view we will consider them.

I would recall in the first place that pleuritic effusions are naturally divided into fibrinous or plastic, and fluid. It is common to use the phrase "pleurisy with effusion" in contradistinction to plastic pleurisy, as though it invariably meant liquid effusion. Such a use of the term is not in this sense pathologically exact, because the fibrinous exudation is as truly an effusion as the liquid; and we should more accurately contrast them as "pleurisy with fluid effusion," and "pleurisy with solid effusion."

These two conditions are practically very distinct. It may be that in most pleuritis with fibrinous exudation there is a little effused fluid; as it is certain there is much flocculent or buttery lymph on the pleural surfaces in large fluid collections. It is probable even that a pleurisy at its beginning may be fibrinous, and give the well-marked to-and-fro friction rub; and subsequently this may disappear, owing to the separation of the surfaces by exudated liquid. But still there is a large number of cases in which, from first to last,

there is the dry crepitant, or the creaking leathery friction rub, and in which no dulness on percussion, or other sign of fluid effusion is ever detected. And so there are other typical examples of fluid pleural effusion in which there are signs of the collection of "water in the chest" from the first, in very definite amount; nor do physical signs of fibrinous exudation occur during the course of them, unless we may suppose them to be represented by the trifling friction, crepitation at the margin of dulness during increase of the fluid effusion, or over the dull area when the fluid has been re-absorbed, and the visceral and parietal pleuræ come again into contact.

The first kind which may be detected, for example, over a lobar-pneumonia, or a phthisical consolidation, or arising idiopathically, can be dismissed, as far as its treatment is concerned, in a few words. Rest in bed in a uniform atmosphere, regulated diet, cataplasms, sinapisms, or fomentations. Sedative draughts for the immediate relief of pain, and febrifuges adapted to the special indications of the causative disease, will be all that is required.

And here, perhaps, I might remark that, in my experience, the pleuritis secondary to or associated with acute lobar-pneumonia very seldom takes any other form than the plastic, or requires any other treatment than the pneumonia, which it complicates.

This statement may require two qualifications. First, I have known an acute lobar-pneumonia in an infant to run the usual course for about a week, the temperature to fall to normal for a day, and congratulations to be given on its commencing convalescence. The next day the pyrexia returned, and persisted for weeks, during which there was a gradual accumulation of pus, producing an empyema, and necessitating drainage. Again, pneumonia in a child, arising during the course of a scarlatina, has been gradually masked by fluid accumulation in the pleural cavity. This was tapped and drained, gangrene of the lung supervened and the patient died. Nevertheless the rule holds good in spite of occasional exceptions, that the associated pleurisy of idiopathic lobar-pneumonia is, throughout, fibrinous.

Another form of pleural effusion of very definite character is what is usually termed empyema. Primary empyema is, I believe, in the majority of instances, a disease *sui generis*. Something altogether distinct from Serous Pleural Effusion. It arises at the first as a collection of pus. I do not affirm that a serous effusion never becomes purulent: I was taught that it sometimes does; and can conceive that it may. I can imagine that a serous collection may, by

tapping, be made septic, as by the admission of septic air or the introduction of a septic trochar and canula; but in my experience such a conversion never has transpired. On the other hand I have known a pleura tapped as many as twenty times, and the fluid remain serous to the last; and I doubt if any pleurisy with serous effusion if not interfered with operatively ever gradually passes into a puriform accumulation. Empyema is, in the majority of cases, empyema *ab initio*.

The line of treatment in this disease seems to me absolutely certain. It is useless simply to aspirate. The fluid will re-collect time and again until the patient is worn out with pyrexia and loss of pus. I have known two instances in which this was tried. In one, after a few tapplings, the child died on the table; in another, after the fifth tapping, the more radical operation had to be performed. The plan, as soon as pus is certified to be present by aspiration, is to incise through an intercostal space and drain by a tube. It should be done, of course, under an anæsthetic, and with antiseptic precautions. In little children, if done early, simple incision without re-section of a portion of a rib has always proved sufficient in my hands. The discharge ceases in from three to six weeks, before the ribs fall together so as to compress the tube. When the patient is older, and especially if the empyema is of old standing with, probably, thickened walls, re-section of part of a rib may be required. As to the treatment of chronic empyema with fistula, that becomes a problem for the surgeons to whom I will relegate its discussion. The treatment of acute primary empyema, adopted early, is as favourable as it is definite. Recovery may be confidently expected and almost guaranteed.

When the empyema is secondary to a pneumonia, or arises in the course of an acute infectious disease, the result, as might have been anticipated, is not so surely favourable. The complicating disease considerably diminishes the prospect of recovery, but the line of treatment is definite nevertheless. The golden rule of surgery holds good: When pus is found evacuate it.

In saying that a primary serous pleurisy seldom, if ever, becomes a true empyema, I would not be understood to affirm that it always retains its original character. I have known an effusion into the left chest to take place rapidly in a young man towards the end of the pyrexial stage of enteric fever. On tapping it was found to be limpid greenish straw-coloured fluid. The pleura rapidly refilled. When next withdrawn the liquid was thick and deeply bloodstained. Again the cavity was filled, and this time with reddish-brown grumous fluid, which would scarcely flow into the aspirator, so the thorax was incised and

a drainage tube inserted, and the patient is to-day alive and well. This, however, was not a true empyema developed out of a serous effusion. Probably owing to the degradation of the blood and blood-vessels by the enteric, the removal of the serum led to oozing of blood from the pleural surfaces, and this blood coagulated and disintegrated in the residual and reaccumulating serum, and so altered its characters.

Another definite variety of pleuritic effusion frequently met with is the Serous. A patient complains of uneasiness in his side of some days or weeks' duration. On examination a large pleural exudation is discovered. An aspiratory puncture reveals its serous nature. What method of treatment shall be pursued? There are two plans available. The one is by counter irritation externally and drugs internally; the other is by removal of fluid by aspiration. Which shall we adopt? I am absolutely confident that neither is suited to all classes of cases, nor should a physician be wedded to the one and divorced from the other.

As a matter of fact a very large proportion of these primary serous pleurisies will, if treated by drugs, be gradually and completely removed. This must be within the experience of us all. The last case of the kind was that of a man who, when he consulted me, had the fluid up to the third left rib with skodaic resonance above. Rest continuously in bed, painting the chest with a mixture of liniment and tincture of iodine, and the administration of a tonic and iodide of potassium have sufficed to completely remove the exudation so that scarcely a trace of it remains. And this would be the first principal in the treatment of these cases which I would lay down. If the pleurisy is serous and has arisen rapidly, temporize and do not tap, because the operation is not necessary, the effusion will probably rapidly subside. It may be asked: "But how can we know it is serous without tapping?" It cannot be known without tapping of some sort—it can only be presumed; but a hypodermic syringe can always be used with impunity for purposes of diagnosis, and its introduction can scarcely be dignified with the title of tapping.

If, however, the general medical treatment does not bring about commencing absorption within a week or two, and the case shows a tendency to become chronic, then aspirate and draw off as much fluid as will readily come. This will in the majority of cases start the resolution process, and will also lessen the quantity of fluid to be removed by the lymphatic system.

As to the quantity of liquid to be withdrawn, it is affirmed that if two or three ounces be taken away it will be sufficient, by the relief of tension,

to bring about the spontaneous disappearance of the rest. This I have never tried. It seems too much like playing with the case, and when the needle is in situ, a pint or two might just as well be taken as an ounce or two, and so ensure the reduction of the tension below the limit necessary to initiate the process of absorption. On the other hand it is certain that no persistent attempt need be made completely to empty the sac: the sensation of the rubbing of the lung against the point of the canula, and the pain and coughing which it generally occasions are indications that enough has been effected. Further aspiration may wound the pleura or pulmonary tissue, and may conceivably result in a variable amount of hæmo-thorax, or even a pneumo-thorax. It is well to remember that "he who will have the last drop out of the tankard may get the lid on his nose."

One tapping would appear to be almost always sufficient. I do not remember to have had to aspirate a second time in any primary serous pleurisy. And although it may be difficult for a few days after the operation to be quite sure whether the fluid is increasing again or not, patience and hope are generally rewarded—always in my experience.

Of course there may be special indications in some cases of primary serous pleurisy, which imperatively demand immediate relief. The fluid may have risen so rapidly, and be exercising such injurious pressure effects upon the heart or the lung on the other side, as to compel its evacuation. One case of much interest I had where a patient suffered intense headache, requiring hypnotics—without pyrexia high enough to explain it—but with much serum in the right pleura. Evacuation by the aspirator gave immediate relief.

Need I point out how careful we should be not to lay open a serous pleurisy by free incision. This would most likely only be done by mistake. And in order to prevent what may then become a calamity, if not a fatality, I hold that unless the physical signs are unequivocally those of hydatid, and probably, even if they are, it is more prudent and to the patient's interest to explore with a fine hypodermic or aspirator needle before proceeding to perform a radical operation for the removal of a supposed parasite. The danger of flooding the lung with hydatid fluid from relief of tension is infinitesimal, the danger of error in diagnosis is calculably greater.

Another class is what may be called secondary effusions. These are necessarily various, and cannot have definite regulations framed for their conduct, because the primary diseases are so diverse.

Of course, if the original complaint is curable this is what demands attention, and the pleurisy may be ignored unless special indications present themselves, for it will subside as its cause is removed. A case of great interest was seen by me in consultation. A lady with ovarian tumour had a right serous pleurisy. This was tapped about twenty times, and the ovariotomy was postponed until the effusion should subside. But it would not, so the ovariotomy was performed, and the water on the chest disappeared.

So in hydrothorax supervening in nephritis or morbus cordis, unless it is the occasion of dangerous pressure symptoms it may be left untouched. As the agency producing it is brought under control it will recede. If it occasion serious embarrassment to heart or lungs it should be aspirated.

When secondary to malignant disease of the pleura life may be prolonged by capillary evacuation; but this will have to be repeated until death closes the scene, which under such circumstances it usually does speedily.

When it arises in the course of a pulmonary phthisis it is difficult sometimes to determine the best line of procedure. Some cases do remarkably well on a purely general plan. For instance, a young lady with marked disease of her right apex is delivered of a child. After a few days there is pyrexia, and within a week the left chest is filled up to the clavicle, with marked rapidity of breathing. While debating the advisability of aspiration the symptoms decline, the fluid rapidly diminishes, and within a month is completely gone, and the patient has since regained her usual health. Nothing could be more satisfactory, and nothing could have been gained by operative interference.

If with phthisical manifestations a pleurisy arose, and proved obstinate, it would probably be necessary to aspirate, and if discovered to be puriform to incise and drain; but I cannot charge my memory with such an experience.

One secondary to hydatid disease I have had and opened with complete cure. In this case the fluid was puriform—loculated in the upper part of the chest at the back, and was diagnosed as secondary to a hydatid in the upper right pulmonary lobe, which had many months previously ruptured into a bronchus and left a cavity simulating a phthisical vomica.

Lastly, there are pleural effusions secondary to pneumo-thorax, and this generally an accident of phthisis. My experience here is not very extensive. In one case of phthisical affection at the left apex there suddenly supervened the symptoms of pneumo-thorax, followed rapidly by complete filling of the chest with fluid. I

aspirated and drew off an enormous amount of nearly clear greenish serum. But it began immediately to re-accumulate; nor did the patient seem much better for the operation or worse for the return of the fluid; but I tapped him again, and removed about an equal amount, and he re-filled, so I left him alone, and he was as well as before his pneumo-thorax, and followed his occupation as a plasterer. Several months afterwards he consulted me, and the condition of the side was unchanged. Ultimately, however, he died from gradual extension of his pulmonary mischief. In this instance free incision, I am inclined to believe, would have been to his disadvantage.

In cases of burst hydatid, causing pyo-pneumo-thorax, the treatment is clear—free incision and evacuation.

PLEURISY AND PLEURITIC EFFUSIONS.

By W. T. HAYWARD, L.K.Q.C.P., &c., Hon. Physician Adelaide Hospital, and Hon. Medical Officer Adelaide Children's Hospital.

I GLADLY respond to the invitation of the Council of our Society to write a short paper on the above subject, the object being, I understand, to elicit the views of the members generally. Such being the intention, I do not propose to trouble you with a thesis on the disease, but merely to bring before your notice some points that I deem to be of importance and interest.

The subject is a very wide one, much too wide to allow of it being treated on properly in a short paper. I believe that it comprises two distinct diseases, diseases that have very little in common, that run a different course, present different symptoms, have different terminations and require different treatment one from the other; speaking broadly, they may be described as the pleuritis that is part and parcel of pneumonia in which the exudation is wholly plastic and never goes on to effusion, and the pleuritis when the lung is not involved, but which results in a more or less copious sero-fibrinous effusion which may or may not become purulent. It is of the latter disease that I propose to say a few words.

To commence with its etiology: almost invariably it is ascribed to "taking cold." For some years past I have been more and more impressed with the idea that "taking cold" retains its position as the chief factor in the causation of disease, more from the undoubted convenience it is to the physician or surgeon rather than to any

logical proof that can be sustained in its favour ; but this is not the time to go into this question, I simply allude to it in passing as I wish to draw your attention to a very interesting and instructive paper in a recent number of the *British Medical Journal* by Dr. Barrs, of Leeds, in which he somewhat summarily dismisses the claim of cold to be a cause in the etiology of pleuritic effusions. Whether his contention that the majority of these cases are due to tuberculosis is correct is another question, and one that I think will require more evidence than he has placed before us to substantiate, still I consider that he has made out a very good *prima facie* case, and the importance of the question demands that it should be thoroughly investigated. Phthisis has long been recognized as a frequent sequel to pleuritic effusion ; but this has been supposed to be owing to the vitality of the lung having been impaired, and thereby rendered a more easy prey to the ravages of tubercle. If it can be proved that the phthisis is merely a development of the same disease that caused the pleuritis, our ideas of the importance to be attached to an attack of pleurisy with effusion will have to be materially altered, for it will necessitate a more guarded prognosis, and such cases will demand more careful observation and supervision afterwards. But, as I said before, more evidence will have to be adduced before we can accept this view in its entirety.

As to the diagnosis of a pleuritic effusion : I suppose there are no two diseases occurring in the same proximity in which the differential physical signs are defined more clearly than in pneumonia and pleuritic effusion, and yet I venture to say that there is not one of us here who has not been puzzled at some time or other as to whether he has had a case of the one or the other disease. For instance, a case presents the symptoms that are common to both diseases ; the friction rub is heard at the commencement of the disease and shortly disappears ; dulness on percussion is found over the base of the lung, extending round to the front of the chest ; the respiratory murmur is absent ; there is no tubular or bronchial breathing ; there is absence of local resonance, and no fremitus is to be detected ; an aspiratory needle is inserted, and it goes into solid lung tissue ; shortly after bronchial breathing is heard, and crepitus redux detected, and the lung gradually resolves. In another case the initiatory symptoms are the same ; on percussion the whole or greater part of one side of the chest is absolutely dull, but bronchial breathing is distinctly audible, as is vocal resonance. Maybe there does not seem much difference in the vocal fremitus between the affected and the sound

side of the chest ; the patient does not improve ; the temperature keeps up ; respiration is increased and embarrassed ; aspiration is resorted to, and a pint or more of pus is withdrawn. In the former case we have a hepatized lung, in which the main bronchial tube to the affected part is plugged with thick fibrinous exudation, preventing the access of air to the alveoli ; the affected lung does not expand, consequently we have not the tubular breathing, increased vocal resonance and fremitus that we expect to find in a case of pneumonia. In the second case we have the sounds produced by respiration in the sound lung of the opposite side conveyed in a modified form to the affected side. These anomalous conditions are found more particularly in the cases of children, with whom the difficulty attendant on the physical examination of the chest renders diagnosis more difficult than in adults. If we bear in mind the fact that the physical signs in these diseases are not constant we lessen the chance of error. It is in empyema that the correctness of diagnosis is so important, and I think that in this disease the physical signs are more misleading than in a simple pleuritic effusion ; especially is this so in the case of encysted empyemata. The use of the hypodermic syringe is a great aid to diagnosis in all cases where there is any question as to whether it is a fluid or a solid that we have to deal with, though it is well not to place absolute reliance on it. I would say also that too much reliance must not be placed on the absence of bulging of the intercostal spaces. Then again, the temperature will sometimes prove misleading, the chart being quite unlike what one would expect in a case where there is a large collection of pus present, but the ensuing temperature is always raised, though, perhaps, only slightly ; that of the morning may be either normal or subnormal. In these doubtful cases the point that has always struck me has been the disparity between the symptoms and the physical signs ; it is not uncommon to come across a case in which the dyspnoea is marked and where there is evidence of imperfect aeration of the blood, in which the respiratory murmur may be heard all over the chest ; it will be found on examination, however, that these sounds are decidedly weaker on the side on which the percussion note is dull, that the heart is somewhat displaced, and if the disease is on the right side the edge of the liver will, probably, be palpable, and on careful measurement the affected side will most likely be slightly larger than the other. The skin is dry and harsh, and though this is a point on which much reliance should be placed, to the experienced eye there is a general expression and appearance in the case that betoken pus.

Before writing on the treatment of pleuritic effusions I thought it might be well to look up some of the authorities and see what they had to say on the subject. I accordingly referred to Von Ziemssen as being the most voluminous writer. I rose from the study of his pages in a state of doubt as to which the patient had more to fear, the disease or the physician. I will give a *résumé* of the treatment recommended. Venesection to six or eight ounces, cupping, administration of digitalis, calomel till signs of salivation are noted. Inunction of mercurial ointment, fifteen grains, every two hours night and day, blistering, dry cupping, sinapisms application of tincture of iodine, large doses of quinine, strong drastic aperients to produce six or eight watery motions daily. A few minor drugs, such as acetate of potash and henbane are thrown in, but no opiates are to be given. The "thirst" cure is also mentioned, but not very approvingly; this barbaric method consists in limiting the food of the patient to lean roast veal and stale rolls, no drink being allowed till the third day when half a pint of wine is given, on the seventh or eighth day a whole pint, and it is mentioned that out of eighteen cases eleven complete cures had resulted; truly a marvellous success! It is hardly surprising to read that when the effusion is reduced to a minimum a prolonged residence in a high-lying, Alpine health resort is necessary to ensure a complete recovery. It is only fair to mention, however, that paracentesis thoracis is strongly recommended when the effusion is very large and when absorption is long delayed.

In great contrast to the foregoing treatment is that recommended by Dr. Bird, of Melbourne, in a paper read at the last Intercolonial Medical Congress, wherein he advises paracentesis as soon as there is evidence of effusion having taken place; in support of his contention he mentions cases in which his patients, instead of having to go to health resorts, were able to resume their occupations—one was an acrobat—at the end of four or five days. I confess that my views of treatment lean decidedly in the direction of the latter method.

In order to enable us to form some rational principles on which the treatment of pleurisy should be based, we may be assisted by noting the course the disease runs when not interfered with by medical or surgical measures. We find that it is ushered in by febrile symptoms of more or less severity, accompanied by intense pain in the affected region, which is increased by any movements of the chest walls. At this stage we have the friction rub, this is followed by the effusion of serous fluid and the separation of the inflamed surfaces of the pleura. At the same time there

is a great diminution in the extent and severity of the pain, the temperature meanwhile keeping some degrees above the normal. Provided the disease runs a favourable course the effusion gradually subsides and convalescence is established in about three weeks or a month, perhaps less, and the chest is very little the worse for the attack. But in many cases there is not this rapid reabsorption of the fluid, and weeks may elapse before there is any evidence of its diminution, and meanwhile it keeps up an irritative constitutional disturbance, and in a certain number of cases the fluid becomes purulent; especially is this so in children and in strumous patients. This being the course of the disease the indications for treatment are, I think, plain. I do not see the necessity for violent antiphlogistic measures. The course I adopt is to put the patient on somewhat low diet, with easily digestible food, for, in common with all febrile affections, the powers of digestion are impaired and any overtaxing of them will produce discomfort, and the flatulence generated will have the effect of interfering with the movements of the chest. It is necessary to see that the bowels act regularly, and that the skin is performing its proper functions, for this purpose mild saline aperients are useful, and such remedies as the acetates of potash and ammonia. Aconite in small and frequently repeated doses tends to keep the circulation low. It is cruel to prevent the patient having the relief from pain that is ensured by the administration of morphia, and here again I prefer small and frequently repeated doses to a larger one given at longer intervals. External applications for the relief of pain are useful either in the form of hot fomentations, poultices, or cold compresses, but blisters and sinapisms are, I consider, unnecessary. Should the disease run a favourable course no other measures are required except the substitution of tonics and full diet at a later period. Should, however, the absorption of the effusion hang fire, other methods must be resorted to in order to ensure its removal. The measures usually employed may be divided into medical or surgical; that absorption does take place in a large majority of cases under the former I think there can be no reason to doubt, whether the time employed is profitably expended is another matter. The means usually employed by those who believe in so acting are the administration of iodide of potassium in various doses, free purgation and the administration of diuretics, blistering, and the use of tincture of iodine, a comfortable (for the physician) routine mode of practice.

I think it a fairly open question whether, in these cases, nature and not the treatment is not

responsible for the cure. I doubt if any conscientious physician can say positively that he can ascribe a good result in these cases to iodide of potassium. As to painting with tincture of iodine I grant that it looks as if one was doing a great deal, but I think the substitution of vermillion would be more striking and equally efficacious. But granting that some benefit may be obtained by these measures it seems to me a very roundabout way of proceeding when we have the easy, safe and certain method of paracentesis at our disposal. I have no hesitation in saying that when we feel that nature is not to be relied upon to remove the fluid expeditiously we ought at once to adopt surgical measures in order to assist her. I am not going to enter into the question as to whether the trocar or the aspirator is the better instrument; I believe both to be safe and reliable. As to the proper time to resort to paracentesis I think we are more likely to delay adopting it than to act too precipitately. It is unnecessary for me to say that in cases of empyema we have no choice between medical and surgical treatment. As soon as the diagnosis is made the only question that remains is what is the best surgical procedure to adopt? I am aware that there are several cases on record where large quantities of pus have been withdrawn from the chest by the trocar or aspirator without any subsequent return of the fluid, but such a favourable result is hardly to be expected, never relied on; in the vast majority of cases other surgical measures have to be resorted to, the object being to secure efficient drainage. Such being the case I deem it wiser policy to adopt the more radical treatment at once. Time will not permit me to enter into the question of the pros and cons of the methods recommended, so I will simply say that I advocate and practise the excision of about an inch of the eighth rib just behind the angle. If care is exercised to excise subperiosteally there is little fear of wounding the intercostal vessels. This being done there is plenty of room for the insertion of one or two drainage tubes, and there is not the danger of them becoming pinched, as is often the case when no portion of rib is removed. If the operation is performed anti-septically there is no necessity for the daily washing out of the chest, provided the cavity remains aseptic; should it become septic solutions of boracic acid or iodine should be employed. It is beneficial, as a rule, to freely flush the chest at the time of operation in order to remove the masses of semi-purulent fibrinous matter that are usually present.

In conclusion, I would strongly urge that operations in these cases should never be delayed. I have never yet regretted having operated, but

many times have I wished that I had so acted earlier.

The PRESIDENT (Dr. J. A. G. Hamilton) thought that before aspirating for ordinary pleuritic effusion other treatment should be tried, especially as empyema did sometimes follow tapping. He agreed with Dr. Hayward that early aspiration was often desirable, but he would not follow it as a routine practice. He had seen an empyema absorbed after aspiration, but advocated incision and drainage as the surer method. He thought a counter opening generally desirable in incising the pleura for empyema. Given strict antiseptic precautions in opening an empyema, subsequent irrigation of the cavity was not, as a rule, necessary nor advisable; in fact harm was often done by the toxic influences of the strong antiseptics so much used as a matter of routine. He advocated the use of small chloral blisters in serous effusions, and had seen total absorption follow the withdrawal of a small portion of the pleural fluid.

DR. CORBIN had that morning refreshed his memory as to the treatment of pleurisy advocated and practised during his student days, 25 years back. This included general bleeding, local bleeding by cupping, tartar emetic, and the administration of calomel and opium. Such had been his early practice. Gradually he had omitted the venesection and dropped his calomel, retaining the use of opium. Morphine had taken the place of bleeding as the sheet anchor of treatment. Blistering he considered a method unnecessary and exploded. Chambers, who at a later date advocated the use of diuretics, especially perchloride of iron, had much improved the treatment of simple pleuritic effusions, but it was reserved for Bowditch to introduce the aspirator ridiculed in 1864 by Aitken. With reference to aspiration, he (Dr. Corbin), drew off the fluid until there was a sense of constriction or distress. He would, with Dr. Verco, draw off pints rather than ounces. He had never met with a case in which repeated aspiration was not followed by complete resolution, nor did he dread empyema following tapping. With regard to resection of ribs, he thought the practice generally unnecessary and unwise; still, a portion of one rib might be excised in some instances with advantage.

DR. JAY believed in early aspiration, and chiefly because of the damage the lung might sustain from the protracted presence of compressed fluid in the chest. A large quantity of fluid in the chest must damage the lung, and adhesions might form tying it down.

He thought that aspiration in a case of chronic pleuritic effusion, with a compressed lung, was a mistake. He did not resect a rib for drainage of an empyema in the first instance. He thought empyema sometimes followed tapping, even where there was no infection from outside. He mentioned a case of spontaneous absorption of empyema in a child, where operation had been unavoidably delayed.

DR. LONDON did not believe in irrigation unless the pus was foetid. He was sceptical as to whether pleuritis with effusion ever became empyema without surgical interference, but this was a point impossible to decide. With respect to the necessity or otherwise for resection of a portion of rib for drainage, he instanced a case in which a soft india-rubber tube produced necrosis of the edges of two adjacent ribs in a young child, which required a subsequent operation. He would like to know exactly what the previous speakers meant by "serous" effusion: was it merely effusion

which was not purulent? He could imagine an effusion of serum occurring into the pleural cavity without deposition of lymph on the pleural surfaces, and that such effusion could be rapidly absorbed, but where lymph was plastered over the pleural membrane absorption of fluid was probably impossible till the lymph itself had become organized and vascular. So far as he knew, there was no means of deciding from the character of the fluid that lymph was absent and absorption was likely to be rapid, and therefore he preferred to aspirate early in all cases, on the presumption that lymph had been deposited, as he thought there was more danger to be apprehended from the condensed lung being bound down than from the expanded lung becoming adherent to the parietes.

DR. BICKLE did not believe in washing out the pleural cavity, nor in too early incision of empyemata. He had seen total absorption follow aspiration in empyema of the adult.

DR. SWIFT had seen several cases of small empyema recover after aspiration. He thought the removal of ribs unnecessary before insertion of the drain tube, or to facilitate the falling in of the chest wall.

DR. SINGLETON asked for information as to tapping when the temperature was high, in primary pleuritic effusions. He was under the impression that it was not generally advocated, but found that pyrexia subsided after aspiration.

DR. HAYWARD was pleased that his paper and that of his colleague, Dr. Verco, had been the means of evoking such an interesting and useful discussion, and he thanked the members for their criticisms. He would like to say in reference to Dr. Verco's remarks as to empyema being a disease *sui generis*, that he thought that there was a great deal to be said in favour of the contention, but that he had purposely refrained from entering into the question for fear of increasing the range of debatable points, so had contented himself with expressing what he considered the generally accepted views on the subject, though he did not consider himself bound to them. He feared that the President had somewhat misapprehended the views he had expressed with regard to the necessity of paracentesis, for though he advocated that procedure at an early stage of the disease, he certainly allowed that in many cases there was no necessity to resort to it. He cordially agreed with Dr. Jay's remarks on this point, and was glad that he had, so prominently brought forward the chief advantage to be gained. Considerable doubt had been expressed by several members as to the necessity for immediate recourse to the radical operation in empyema and the advisability of resecting a rib, and notwithstanding Dr. Bickle's remarks he strongly adhered to the opinion that so soon as pus was known to be present the chest should be opened without delay; it was a mistake to be guided by an exceptional case, no matter how successful it might have been; he attributed the loss of a case in his own practice to unfortunately remembering the case alluded to by Dr. Bickle, which induced him to delay further operative proceedings till too late. Though undoubtedly incision between the ribs permitted sufficient drainage in most cases, still in other cases such was not the case, whereas if *one* rib were resected there was no fear of such a result, and as he had never found that the operation had interfered in the slightest degree with the subsequent condition of the chest wall, he thought it wiser to adopt the procedure at first, and so not risk the necessity for a second operation. In reply to Dr. Singleton's remarks he would say that he did not consider the presence of pyrexia a bar to paracentesis; on the contrary, it might be, and often was, an extra reason for its performance.

NORTH QUEENSLAND MEDICAL SOCIETY.

At the First Annual Meeting of this Society, held in Townsville on June 17, the proceedings of which appeared in our last issue, the President (Dr. Jos. Ahearne) delivered an exhaustive address, but owing to the great pressure on our space at this time of the year we regret that we can only publish the following extracts from his interesting Presidential Address:—

GENTLEMEN,—It is an honourable position, truly, in which I find myself to-night; my appreciation of the dignity conferred in selecting me as your first President of the North Queensland Medical Society is sincere; and my thanks for your generous consideration I wish you to accept as a no mere conventional tendering. I convey, on behalf of my Townsville colleagues and myself, a hearty welcome to those who have come from a distance to assist in our inaugural meeting. We may justly congratulate ourselves upon being present at the birth of a Medical History of North Queensland, and I have no hesitation in believing that its records of the future will afford evidence of careful research and brilliant development in the science of medicine. Whatever results shall attend our career of success, and whoever may gain distinction by efforts inspired through our Association, let it be always remembered, the credit of our formation is due to the perseverance of DR. VAN SOMEREN. A society of this kind presents numerous advantages to its members; not the least are those derived from social interchange, by which a knowledge of individual character can lead to intimacies that probably otherwise would never be formed. *Professionally* we must benefit by being urged to keep more accurate notes and extensive accounts of cases than possibly most of us now do; a friendly rivalry quickly arises, and so a greater attention to scientific investigation necessarily follows; the educating influence of personal experience is immediately felt; interest is excited through tangible demonstration, as it were. I need not dwell on the superiority of demonstration over book reading; subjects for discussion stimulate study, and help to recall one's own experiences of cases long hidden in cerebral dark corners.

The general public of North Queensland will be extensive gainers at our hands. It is common to hear, in matters of common weal, "What does the Doctor say? We'll leave it to the Doctor." The people, apparently, are willing to be guided—and they want direction badly; none too soon for them are we constituted. Townships are ever being started, land is sold, streets are formed, and no care bestowed upon hygienic considerations. As a body, we can be powerful in pointing out the way to obviate mistakes, and if we prove worthy of our high responsibility, the great mass of the people (intelligent as is the majority) will support us in securing reform against the speculator in land and the negligent or stupid town councillor.

To the profession at large our Society will have its advantages. In these days of close application and earnest search after knowledge, opportunities arise in our varied work to further the science in the practice of which we are engaged. Contributions are gladly accepted by the numerous medical journals; these owe their special value, not so much to editorial articles and copies of professors' lectures, as to the painstaking reports of interesting cases met with in general practice and in Hospitals. There are none of us who could not add to the accumulation of proof that ours is a profession in which each individual can sometimes help his neighbours by recounting his experiences. The current literature issued in the journals is of the greatest

importance to the working medical man, as there we get the latest practice and results. We are fortunate at having in this country that able periodical, the *Australasian Medical Gazette*. The editor has courteously signified his desire to forward our Society by publishing our proceedings, and I have no doubt at all we shall not infrequently supply his paper with matter that will interest his many readers on this continent and elsewhere.

On this occasion I would ask your attention for a short period while we consider our surroundings. We find ourselves in the tropics; certainly a strange, if not an unnatural habitat for the European. The few moments you permit me to detain you may be devoted to enquiring whether we are living in as rational a manner as possible under our novel conditions.

Now, I would propose for your consideration—

- (a) Is *our* race being affected by residence in North Queensland?
- (b) To what diseases are we liable?
- (c) What precautions are we to take in combating existing complaints, and preventing the appearance of those not yet endemic, but found so in similar parallels of latitude?

I took the liberty of troubling you with a circular list of inquiries. The result goes to show, by a majority of expression—

That a modification of type is in course of formation.

That the change is evident from the age of three till second dentition, varying in the individual.

That it asserts itself by pallid appearance, a wiry physique, and nervous temperament.

That adaptation to the new climatic conditions may be hoped for without any effect upon longevity.

That the continued admixture of European blood is advantageous.

Special condemnation has been made of the injudicious use of unsuitable food, both in eating and drinking, and of the excessive amount of alcohol that is so generally consumed.

Two of my correspondents have remarked on the fecundity of freckles, one saying, "This is but a superficial indication, I know, but may have its, as yet unascertained, significance." I may here, in passing, quote Dr. Sharpe, in the *Anthropological Review*. He remarks "that a tropical sun, which burns and blisters a white skin, does not injure a black one at all," and he adds, "this is not due to habit in the individual, for children only six or eight months old are often carried about naked and are not affected." I have been assured by a medical man that some years ago, during each summer, but not during the winter, his hands became marked with light brown patches, like, although larger than, freckles, and that these patches were never affected by sun-burning, whilst the white parts of his skin have on several occasions been much inflamed and blistered.

To return to the first question: "Is *our* race being affected by residence in North Queensland?" Analysis of your replies, which will be summarized if you wish it, compels me to say *Yes*, and the agency at work I declare to be *anæmia*. Here I am brought to the consideration of the diseases to which we are liable.

We have been so far singularly free from many of the maladies to be met with in other tropical countries. Of course we have our own malaria, but certainly, in the district which has Townsville for a centre, its character has become modified exceedingly, and its appearance is but rare in comparison with half-a-dozen

years ago. I well remember the shocking sights of prostrate men, stricken to deplorable helplessness by the terrible virulence of pernicious malarious influence, who constantly were received in the earlier times at the hospital here from the parties engaged in clearing the scrubs on the rivers in the north. This form I hope to see no more.

We seldom meet tropical abscess of the liver—splenic enlargement is rare; I occasionally find it in patients from Cairns—dysentery is not general—true cholera is unknown—dengue but a name—beri-beri familiar only from reading—sunstroke is generally associated with alcoholic excess; but we have *intertropio anæmia*. What means the change from the chubby child to the elongated stripling with parchment skin and freckled face? To what is due the almost universal languor, the absence of energy, the frequent attacks of indisposition amongst our women? Let me read what Hirsch says in his *Geographical and Historical Pathology*—"All observers agree that *anæmia* is a characteristic morbid phenomenon of tropical regions, and that as a symptom it is found mostly among the white residents, although it may be observed to no small extent among the coloured races also. There seems to be hardly any question that the peculiar influence of tropical climate which is called relaxing, and which cannot be otherwise defined in physiological terms, is, for white people not habituated, a very material factor in the development of this disorder of nutrition. But it is clear that malarial influences contribute not inconsiderably to it. Experience shows, moreover, that the *anæmic* habit of body in white residents of the tropics communicates itself to their offspring, and therein lies the chief obstacle to the acclimatization of the white race in the tropics."

We may fairly regard cholera and small-pox as possible arrivals at any time from our frequent communication and intimate traffic with the East, and one might even come across a leper some day. Cholera has been proved to be indigenous at certain points on the earth's surface; and its extension beyond those points depends on the conveyance of the specific agent that gives rise to it, or in other words, of a poisonous substance.

How we should fare (with the infectious character of cholera, and its communicability granted) were it introduced in North Queensland, I would fear to indicate. The seriousness of the situation may be gathered from this important fact:—In this town there are, roughly, 3,000 closets; there is only one nightsoil contractor; he has but 500 engagements to attend. How is the excrementitious matter of the other 2,500 disposed of?

The influence of the effect of vaccination on the prevalence of small-pox needs no comment. Despite the danger which is *ever* imminent to us; despite the effect in countries where vaccination is regulated by statute, *nine-tenths* of our population are allowed to continue unprotected against the most loathsome disease to which man is heir.

I have said we may occasionally meet with a leper. I believe I have, in my ten years' practice here, met two. One suffering from the *anæsthetic* variety seen with me by Dr. Van Someren, conveniently died from asphyxia a few days after he came under observation; the other, a tuberculous leper, I shipped home to his country, with the approval of Sir Samuel Griffith, the then Chief Secretary. I am of opinion that it is injudicious, in the interest of the people, to noise abroad the discovery of such cases. The general public of Australia are easily aroused into a temporary scare over matters of disease—witness the excitement all through the continent, and the absence of *savoir faire* con-

spicuous in the heads of Governments, when a ship is off the coast with a case of small-pox reported. The wretched leper stands a poor show with the policeman as a guardian and attendant. I have heard of an unfortunate Chinaman, who for some time was detained in a police compound, in a tent or hut, out of which he used to be poked with a long 10ft. stick when he was wanted for show purposes, and who received, on the end of the same safety wand, the vessels conveying his victuals.

Now to typhoid—which we have with us in more or less serious phases. Comparatively in our infancy, we may take warning from the observations of Dr. Jamieson, of Melbourne, where the disease prevails principally during the summer months. He has been led to the conviction that in most cases of localized outbreaks of typhoid in Melbourne there existed marked and special defects of *drainage*, and very often underground drains, which are too frequently badly laid, badly trapped, and with no means of ventilation, except by the inlets from yards or houses. We are thrown back upon the well-established facts that a *filth-saturated soil* supplies a condition eminently favourable to the spread of typhoid, and that a proper system of drainage, however it may operate, can be depended on to reduce steadily and to a large extent the prevalence of the disease. The best possible system of drainage cannot, of course, prevent danger arising from milk, or put an end to other possible modes of communication; but, judging from experience gained in the large cities of Europe, it may safely be said that no other measure of precaution, no other sanitary improvement, can be compared with this in certainty of effect.

I have still yet to mention alcohol to bring before your mind a train of diseases that pass familiarly in review. Renal and hepatic derangements—paralysis—insanity—all form up on the sound of the word. Although it be a cause of numerous ailments not peculiar to tropical settlers, the subject is worthy, to us, of attention.

And now I may fairly come to what I consider the most important part of my address.

What precautions are we to take in combating existing diseases, and preventing the incoming of those not yet endemic, but found in similar parallels of latitude?

The leper I should deport; small-pox render impossible, through compulsory vaccination by statute; the stay of cholera, if it did invade us, would be short; typhoid would be unknown in a malignant form; malaria might be expected to disappear almost; anæmia would grow rarer, and the maladies due to alcohol lessen, if the all-important laws of hygiene and sanitation were attended to as they deserve.

I think you will agree with me that an elementary knowledge, at least, of sanitary matters should be insisted on by municipal voters as a first qualification from those who seek the honour and accept the responsibility of conducting corporation affairs.

A health officer should be appointed in each town, who, in reality, ought to be the most important official of the community. The inspection of drains, closets, milk, water, food, and the making of arrangements for disposal of the dead, all important, are subjects for the specialist alone.

Investigation has succeeded in demonstrating the terrible mortality which impure water inflicts on all classes. The effects of bad water, like those of impure air, may give rise to an impairment of health, without giving rise to well-pronounced disease. It is well known that ague has decreased, in districts where formerly it prevailed, when bad water has given way to a purer supply.

There remain the most important subjects of food and drink to be touched upon. I have had from you a general expression of opinion to the effect that beef is eaten to excess. I quite agree with this view. One would be inclined, from their love of flesh meat, to describe North Queenslanders as an almost purely carnivorous race. From an absurdly early age it is the habit to permit children the use of meat; indeed, before they can chew, I have frequently seen them encouraged to suck it. What an immense amount of unnecessary physiological labour is employed in devouring this wasteful food! I may remind you it takes 4lbs. of fatless meat to yield sufficient carbon in the day's consumption of a full-grown man; whereas in the same quantity he would receive three times more nitrogen than necessary. The excess must be got rid of by mighty efforts on the part of the digestive apparatus, beginning with those important agents the teeth.

The premature decay of the teeth is doubtless due partly to the wearing of the young enamel by the too early mastication of coarse animal food, as well as to the general use of rain water, and the want of inclination for or the scarcity of vegetables. Dentine contains 72 per cent. of Phosph. and Carb. Calcium, and enamel contains 96 per cent. of the same. Rain water is free from these salts, and vegetables contain them largely. Mark the significance. Dr. Macdonald, of Ingham, informs me that Kanakas arriving with the white strong teeth we are accustomed to find in the black man, suffer greatly from their decay after a short residence at the plantations, where their diet is largely a meat one.

Tea, in its abuse, should be severely condemned. Tea drinkers are almost general; they are perhaps not aware that this leaf has an intensely inhibitory effect on salivary digestion, which is due to the large quantity of tannin it contains. Coffee and cocoa are not so astringent. The only way to mitigate the inhibitory effect of tea on salivary digestion is not to sip the beverage with the meal, but to eat first and drink afterwards. Tea *sots* are numerous; they are well known to be effected with palpitation and irregularity of the heart, as well as with more or less sleeplessness, mental irritability and muscular tremors, which in some instances culminate in paralysis.

Green vegetables are especially rich in salts, which resemble the salts of the blood. Their value is attested to by the serious defects of nutrition, such as scurvy, which result when they are not supplied. All substances necessary for the food of animals occur in vegetables. Plants contain fats—carbo. hydrates and proteids. Cows' milk and wheaten flour have the right proportion of nitrogenous to non-nitrogenous substances.

Other things being equal, carbonaceous substances ought to contain a preponderance of starchy or farinaceous constituents in warm climates.

Meat eaters require more stimulants than vegetarians. The desire for stimulants being one of the strongest instincts of human nature, whatever course would tend to diminish the craving should have our earnest support.

The public will drink, but they ought to be protected; the *least harmful liquors* should be made popular and cheap, and yet when an opportunity was afforded us the other day by the South Australian Treasurer's proposal to enter into a reciprocity treaty—which, when enlarged, would have enabled us to get sound wines cheaply—the South Queenslanders did us the injustice of rejecting it. The advantages to us in price would have been at least 12s. a case. Last year, at the local Custom House, 67,049 gallons of spirits

were imported, and only 15,302 gallons of wines. Let us endeavour to turn the figures the other way.

The Gothenburg licensing system should be advocated. It has worked so well and to such good effect as to reduce the average of drunkenness 22 per cent. between 1866 and 1876 in that town. There, the ratepayer who drinks participates in the profits of the sale of the liquor consumed, as the town grants the whole of the public-house licenses to a company, which places managers at fixed salaries in the houses. After paying the expenses of management, with 6 per cent. annual interest on the shareholders' capital, the company makes over the profits to the town treasury, to be used as the statutes may direct.

The final matter with which I shall trouble you relates to our State schools. In regard to the buildings, I have found that no attention has been given to the hygienic requirements of our northern climate. All the schools throughout the colony are built after a design suitable for the Darling Downs, with one exception; I believe the Croydon people, greatly to their credit, would not have the stereotyped plans, and some alterations to suit the situation were eventually effected.

I have had several instances of female pupil-teachers breaking down under the extraordinary strain to which they are subjected over a period of three or four years, just at the age when, in this climate, the greatest care should be exercised in conserving energy.

What is our duty? The noblest work of the noblest profession is to prevent suffering and prolong life. Have we difficulties in the way? Let us face them in the municipal chambers, and fight bravely in the struggle for success, as we individually grapple daily with disease and defeat death. In these days, when the power of combination is shown by the success of labour organizations, we cannot fail if we band ourselves together to demand, for the sake of the living and the unborn generations to come, that well-considered measures of sanitary reform shall hold a prominent place in the future transactions of our local representatives.

Let us fight the people for their own good; educate them, and, if need be, ridicule them for their carelessness and folly—but impress them.

People pay the least attention to that which ought to concern them most. Arts and varied sciences are dabbled in, and form the subject of conversation; but what is sculpture if your limbs are deformed and your bones rickety? What is music if your head throbs from plethoric habits, or your nerves are disordered by a dyspeptic stomach? Money is sought after greedily—wealth accumulates. But at what expense? Health is capital—a sound body the noblest example of unique sculpture; the hearty laugh of a healthy man the jolliest music.

PROCEEDINGS OF COLONIAL MEDICAL BOARDS.

The following gentlemen, having presented their diplomas, have been duly registered as legally qualified Medical Practitioners by the respective Boards:—

NEW ZEALAND.

Thomas, Charles Ernest, M.B.O.S. Eng.
King, Frederick William John Robert, M.R.O.S. Eng., L.R.C.P. Lond. 1890.

VICTORIA.

Reid, Peter Macpherson, M.B. & Ch.M., Edin. 1889; M.R.O.S. Eng. 1889; L.R.C.P. Lond. 1889.
Clarke, William Hughes, M.R.C.S. Eng. 1884; L.S.A. Lond. 1885.
Flowman, Sidney, F.R.C.S. Eng. 1886; L.R.C.P. Lond. 1885; L.S.A. Lond. 1884.
Davies, Samuel Hickman, L. & L. Mid. R.O.P. & R.C.S. Edin. 1890; L.F.P.S. Glas. 1890.

NOTICE.

The Editor will feel obliged by any gentleman, who wishes to ventilate any subject of professional or public interest, writing an editorial or leading article on it, which if found on perusal to be consonant with the policy of the paper, will be inserted in an early number.

All communications intended for the Editor should be sent to the 'A. M. Gazette' Office, 35 Castlereagh Street, Sydney.

** * Contributors can have their Papers reprinted and published in Pamphlet form, at Cost Price, if the necessary instructions are given to the Publisher at the same time the contributions are sent in.*

AUSTRALASIAN MEDICAL GAZETTE.

SYDNEY, AUGUST 15, 1890.

EDITORIALS.

THE WESTERN MEDICAL ASSOCIATION AND THE PARRAMATTA FRIENDLY SOCIETIES' MEDICAL INSTITUTE.

In our last issue we published the circular of the Association addressed to the various Friendly Societies of the Parramatta district, and we think it wise to follow this month with a report of the proceedings of the recipients in regard to it. How fair are the demands made by the Medical Association as to the treatment and payment of medical men by these lodges is shown by the impatient spleen displayed by the various speakers with regard to them. For the present we content ourselves with earnestly recommending medical men, not only in Parramatta but throughout Australia, to be loyal not only to the principles of the Western Medical Association but to themselves and their interests, for, if they are, the very reasonable demands made must be acceded to, and something like fair remuneration for efficient medical services paid. In our opinion nothing could be more fatal to the well-being of the sick members of the various lodges than the success of the various governing bodies of their societies in coercing heedless medical men into acceding to their unjust efforts to obtain professional services for inadequate pay. Small pay will mean careless and inferior professional attendance by an overworked, anxious man, rendered unfit for duty by pecuniary anxieties and excessive physical and mental work.

MEETING OF THE INSTITUTE.

At a special meeting of the Parramatta Medical Institute, held on July 17, the circular from the Western Suburbs Medical Association was read.

A motion was moved and seconded that a committee of the President, Secretary and Treasurer wait on Drs. Garrett and Hart, and elicit an opinion from them as to what extent the Association would affect them professionally and socially, and report to the next meeting of the Board, the mover contending that they would have something definite to work upon then.

An amendment was moved and seconded that the letter be not received. The best way, it was generally urged, was to treat the letter with contempt, and to show the doctors that they would not recognize them in any way. It was stated that the Association really only existed in Parramatta, and that other independent doctors had been enrolled as honorary members to make the affair appear larger than it really was. Others of the delegates also spoke of the treatment the various lodges they represented had received from the hands of the Parramatta doctors, and simply for their own protection they had been compelled to band together with the other lodges for their own benefit in the formation of the Medical Institute, which no doubt was an annoyance to the doctors, as young doctors were brought to the town with a fixed salary by the Board and allowed private practice.

The President stated that he had the honour to be a member of the Board of the Sydney Friendly Societies' Dispensary, where some 36 societies, representing about 8,000 members, were attended by about 32 doctors; and he believed he was correct in stating that not one of those doctors belonged to the Medical Association, so that the circular was not quite so serious as it appeared to be.

One of the delegates, in referring to a paragraph that appeared in a contemporary, stating that quite a consternation had been created amongst the lodges, repudiated the statement altogether. It was no such thing. Neither in his own or any other lodge, as far as he could learn, had there been any excitement or consternation over the circular.

After nearly all the members of the Board had expressed themselves in a similar strain, a further amendment was moved that a public meeting be called of the societies affiliated to the Institute, of those not affiliated to the Institute, and of the general public, to take into consideration the circular, and to show the benefits to be derived from being a member of a benefit society, and also from belonging to the Medical Institute.

The motion lapsed for want of a seconder, it being the general opinion that it would be a waste of money and simply advertise the doctors.

The amendment was almost unanimously carried that the letter be not received.

The secretary was instructed to draw up a circular and submit for consideration, showing the benefits to be derived from the Institute, to be forwarded to societies affiliated and not affiliated.

The Secretary announced arrangements that had been made in reference to the meeting that the Board had called for Thursday next, requesting non-affiliated societies in the surrounding districts to send delegates to confer with the Board *re* increasing the usefulness of the Institute, with a view to their affiliation.

A resolution was unanimously adopted that the members of the Board pledge themselves to do all they possibly can individually in their several lodges and elsewhere to further the interests of the Medical Institute, and do all they can to secure private practice for the

medical officers of the Institute, and that a copy of the resolution be forwarded to the medical officers of the Institute.

During a discussion on the above resolution it was stated by several of the delegates that some of the greatest opponents to the Medical Institute at its formation were now to be counted amongst its warmest advocates, so that the circular from the Western Suburbs Medical Association had been the best thing that could have happened to the Institute.

About 20 delegates from lodges in Granville, Auburn and Rookwood conferred with the Board of the Parramatta Friendly Societies' Medical Institute on July 24 with a view to considering the advisability of the former lodges affiliating with the Institute. All the delegates present were favourable to the proposal, providing a medical officer was stationed at Granville. It was estimated that the Rookwood, Auburn and Granville lodges would number 700 members. The opinion was expressed by the Board that there were sufficient numbers to justify them in placing a doctor and dispensary at Granville. The Granville, Auburn and Rookwood delegates will meet at Granville next week and decide on a course to recommend to their lodges.

The Orange Blossom Lodge, No. 40, I.O.O.F., N.S.W., Parramatta, met on Tuesday evening and decided not to receive the circular from the doctors.

The Parramatta Branch of the A.H.C. Guild also met and decided not to entertain the doctors' circular.

The circular was also read at a meeting of the Loyal Fountain of Friendship Lodge, M.U., I.O.O.F., Parramatta, when a motion was carried "that the circular be not received and treated with the contempt it deserves."

The Inspector-General of Charitable Institutions in New Zealand feels very strongly in this matter, and we think the portion of his report which we reprint below fully supports the view taken by the Western Medical Association as to the relations between the Medical Officers and the Councils of the various Benefit Societies, which the latter seem so desirous of perpetuating.

The passage in Dr. Macgregor's report on Hospitals and Charitable Institutions in the colony, is as follows:—

"As I have indicated in former reports, the hospital system has close and intricate relations, not merely with the whole problem of charitable aid, but with the whole social life of the people as well. For instance, the good done by Friendly Societies is not without some drawbacks. One of their least noticeable effects is to increase the number of our hospitals. The lodge system is so prevalent that in nearly every community a very large proportion of even well-to-do people are members for the sake, among other objects, of getting medical attendance cheap; and several of the largest societies admit honorary members, who join merely for the sake of getting medical attendance at lodge rates. The result is that the doctor has so few paying patients that he must either leave or get a State subsidy. Every effort is made accordingly to found a hospital, not because it is really wanted, but because the residents cannot get a medical man to settle without some guarantee, which is thus thrown largely on the State. A good many of our hospitals exist for the simple reason that, as things are, it is the only way of getting a doctor to stay. One hospital chairman was so candid

as to tell me they wanted to keep the hospital going because it enabled them to have a second doctor to call in to assist the other, who was already there, in certain cases."

ACTION AGAINST THE SOUTH CANTERBURY (N.Z.) HOSPITAL BOARD.

At a sitting of the Supreme Court of New Zealand, held at Timaru on June 27, an action was brought by Thomas Grace against the South Canterbury Hospital Board for £500 damages in consequence of his child, an infant of seven months, having been scalded by a steam kettle used in its treatment for bronchitis. We think the remarks of His Honor, Mr. Justice Denniston, when giving his decision, so shrewdly just and practical that we feel it a duty to reprint the following portion of them—

"Was the board responsible because the convalescent patient in charge neglected her duty? He did not think so. The hospital was under no obligation to take in so young a child, and only did so to save the child's life, and the doctor told the mother that he had no nurse to give the necessary constant attention, but that her place (the mother's) could be taken by a convalescent patient. This patient was shown to the mother, and she was obviously old enough to undertake the task. It would be a monstrous doctrine that under such circumstances the board should be held liable for such an accident as had occurred. He had come to this conclusion without considering the conduct of the plaintiff. The injury had been ridiculously exaggerated. The child had certainly been badly burned, but its life had been saved almost against the parents' will by the insistent humanity of the doctor. In doing so an accident happened, such as might happen in any household, and it had resulted, it seemed to him, in comparatively slight injury. Yet the parents, after their child's life had practically been saved by the insistence of the medical officer, had the impudence—he must say the impudence—to ask for £500 as compensation for that trifling injury. Whatever compensation might be granted, it could by no means be very much, would not benefit the child but the parents. He did not base his decision on that ground, however, and even though the child had sustained this injury through an act of technical negligence on the part of the board, this action was one which the plaintiff ought to have been ashamed to bring. Judgment for defendant with costs."

DR. TREVOR (Ashburton) writes to the Christchurch editor of the *N.Z. Medical Journal*:—"I have been intending to ask you for some time past to warn the profession, through the *N.Z. Medical Journal*, of the danger they run in using hypodermic syringes made in France or Germany. They are not marked for English measurement, although it looks exactly the same, but on measurement 5m. is exactly 10m. English measurement. I found this in one I obtained for the Hospital, and on examination of the stock kept by the chemist, they were nearly all the same. The wholesale firm from whom they were obtained stated they had sold a great number of the same kind. There is nothing to distinguish them from others with English measurement, consequently I fear serious mistakes must happen."

LETTERS TO THE EDITOR.

DR. HARDIE'S HYPERCRITICAL CRITICISM.

(To the Editor of the A. M.G.)

SIR,—Dr. Hardie is painfully severe on me, and I am smarting under the lashes administered by this highly scientific gentleman on his unscientific *confrère* anent the case of acute yellow atrophy of the liver I published in last month's *Gazette*. Why he should be so wroth at my asserting the possibility of this formidable disease terminating in recovery, may possibly find explanation in the fact of his having published a month previously a number of fatal cases out of his own practice. Let me assure him that this apparent affront, if such he takes it to be, was perfectly unintentional on my part, as the manuscript of my article was in the hands of the publisher for some time previous to his own appearing.

When writing on a subject, all our knowledge of which amounts, after all, to mere hypothesis, or at best to theory, without absolute proof, I had a perfect right of indulging in a little of both, more especially since my conclusions, drawn from a single case, were merely advanced tentatively, and without any claim to finality. Dr. Hardie rates me severely for this, and considers it highly unscientific, yet his own article referred to is nothing but assumption and speculation from first to last.

He is equally unjustified in charging me with ignorance of the liver-structure, making it appear as if I looked upon the liver cells as so many vesicles, each having its own discharging duct. "*About the finest ramifications and ultimate ends of the bile ducts in (or among, but not within) the secreting cells,*"—Dr. Hardie knows as little as I do, for this is still an unsolved problem. It is also by no means settled yet, whether there is not between the cells and the capillaries encircling them, some connective tissue, and I have as much right to assume that there is as he has to deny it, and perhaps even a little more. Professor von Eulenburg has not only demonstrated that the capillaries, on entering the asini, take with them cellular tissue, but has also shown a considerable increase of thickness of this tissue in acute yellow atrophy. In minute and microscopical anatomy, however, I do not pretend to be "*au fait*," for it is nearly forty years since last I sat on those benches "*where much is learnt, for much to be forgotten*." When Dr. Hardie has forgotten a little more of the minutiae of knowledge that now appear to him essentials, he will probably be better able to bring essential knowledge to bear on the practice of his profession and not mistake yellow atrophy for uraemia, actually requiring a few fatal cases before making a correct diagnosis of subsequent ones.

But Dr. Hardie's criticism of my article is not merely carping throughout; it is even lacking in honesty. Thus with regard to the age of my patient he quotes Frerichs as an authority against the disease appearing in childhood, yet this very author gives among 31 cases 6 as having occurred between the ages of 10 and 20. My patient was 11 years old. The rareness of the disease in childhood, which I pointed out, makes my case all the more noteworthy, but cannot be used as an argument against the correctness of my diagnosis. Dr. Hardie seems fully convinced that, because the boy recovered, he could not have suffered from genuine acute yellow atrophy, and starting from these false premises blunders from one false conclusion into the other one. He points to the early delirium as a

suspicious symptom, yet he must know that there are cases on record in which the disease ran a fatal course in 12 to 24 hours; he must know that the nervous symptoms, of which the delirium is the principal one, always set in early in the second stage. In this stage my patient had been for hours before I saw him, and Thierfelder gives its duration in 72 out of 118 cases as from 1½ days to 3 days.

With regard to the subnormal temperature, Dr. Hardie writes:—"It is acknowledged that when delirium sets in, there is generally a rise of from two to four degrees." By whom, except by Dr. Hardie himself, is this acknowledged? Frerichs found the skin invariably cool and dry. Alison, Bright, Thierfelder, Eulenburg, and others, made the same observation, the latter finding the temperature subnormal even at the finale, when alone it generally rises.

Dr. Hardie makes much out of my statement that the area of hepatic dulness over the right lobe, vertically, was nearly two inches when I examined the boy first, but does not bear in mind that the shrinking almost invariably commences in the left lobe, and that the area of dulness being nearly normal simply shows the right lobe not to have been affected at the time.

Since I wrote the article under review I have made a very interesting autopsy on the body of a Chinaman, which strongly illustrates this point. As the body had been brought in from the country I could gain but little information about the history of the case, except that the man had been delirious for two days before his death. The body was intensely jaundiced, the left lobe of the liver was greatly atrophied, being reduced to less than one-fourth of its natural size; but the yellow appearance and the shrinking had only extended into a part of the right lobe, by far the greater portion of it being in a condition of intense engorgement and biliary congestion. Closure of the ductus choledochus through a very large scirrhous of the pancreas had evidently caused the hepatic disease, but how long it had preceded death I could not ascertain.

But I fear that I am trespassing beyond the limits usually allowed for a letter of reply. To cut the matter short, I must ask my learned opponent what he takes the disease of W. G. to have been if it was not acute yellow atrophy? My notes surely are explicit enough to enable him to answer this question, and the position he takes up renders him in duty bound to give others the benefit of a knowledge which I for one openly confess not to possess, for in the whole domain of pathology I know of no other disease bearing features like those observed and delineated by me. There is also among the known toxic agents, phosphorus included, not one producing the same complexity of symptoms. *Nolens volens*, therefore, unless he can answer this question, Dr. Hardie will be obliged to admit that the case was one of genuine yellow atrophy of the liver; and however faulty he may deem my exposition of the pathological condition obtaining in the liver of the boy to have been, the marked improvement following in every instance after the evacuation of the black putrid stools must force on him the conviction of a causal connection existing between these two occurrences.

He must also bear in mind that the treatment pursued by me had equally beneficial effects in the two cases published by Drs. Creed and Scot-Skirving in the *Australasian Medical Gazette* for July, 1889, and that it is extremely improbable for these two eminent practitioners to have both been mistaken in their diagnosis.

An early diagnosis, if possible at the very commencement of the second stage of the disease, and a vigorous cholagogue treatment pursued from the first, these are

the two lessons I wished to convey by publishing W. G.'s case, and if Dr. Hardie will take them to heart and publish his successful cases with the same candour as he did the unsuccessful ones he will be entitled to the lasting thanks of his professional brethren and suffering fellow men.

I am, &c.,

A. MUELLER, M.D.

Yackandandah (Victoria),

July 24th, 1890.

DEATH CERTIFICATES.

(To the Editor of the A. M. Gazette.)

DEAR SIR,—I have just received the new death certificate forms issued by the Registrar-General.

This certificate form will be the means of the public detecting who are legally qualified, and is one step in the right direction.

I think I may claim the honour of this reform, as I have frequently written to the papers and also to the late Registrar on the subject, and from the late Registrar I received a letter intimating that he would look into the matter.

Apologising for intruding,

I am,

Very truly yours,

E. J. A. HAYNES.

Gunnedah, N.S. Wales,

July 28, 1890.

[The new form requires that the deceased's name, age, date of last visit of medical attendant and of death, place of death, name of primary and secondary disease with duration in years, months, days or hours of each, date of certificate, together with the signature of the medical man certifying, followed by his *registered qualifications* and address shall be stated. We think this change in the conduct of the registration of deaths introduced by Mr. Pinhey, the new Registrar-General, a very great improvement, and congratulate both him and the public on it. The claim made by our correspondent that he has been the cause of this reform is hardly tenable, though we fully admit that he has taken praiseworthy public action in the matter. We have reason to know that the attention of the new Registrar-General was called to the report of the Select Committee appointed by the Legislative Council to enquire into the "state of the laws relating to the registration of births, deaths and marriages, and the administration of the same," and that his action has been consequent on it, and upon the startling facts in the evidence given by the various witnesses examined by it. The law is very defective, and a Bill to remedy the various evils, founded on the report, was introduced by the editor of this journal in the Legislative Council, but it was ruled out of order when initiated in that House, as some of its provisions necessitated the expenditure of public money. The reason of the delay in the action now taken for reform in this matter is traceable to the fossilized state of the Registrar-General's office which continued until the present head took charge.—ED. A.M.G.]

Massage.—MR. ERNEST T. KING (pupil of Dr. Roth) undertakes male massage under the supervision of medical men. Address—269 Iona Terrace, Victoria Street, Darlinghurst, Sydney.

THE NEW MEDICAL BILL FOR VICTORIA.

THE Bill relating to medical practitioners, introduced in the Legislative Assembly of Victoria by Mr. Deakin, is one which has been prepared by the Medical Societies of Victoria, only a few unimportant amendments having been introduced into it by the Government. It is to be known as the Medical Act 1890, and is divided into four parts, as follows:—Part 1, the Medical Council of Victoria; part 2, Legally Qualified Medical Practitioners; part 3, Medical Witnesses; and part 4, Schools of Anatomy. The Bill abolishes the Medical Board of Victoria, and creates in its stead a council, to be styled the Medical Council of Victoria. The Council is to consist of fifteen members. Of these, four are to be appointed by the Governor in Council, 10 to be elected by the registered medical practitioners resident in Victoria, and one to be elected by the Senate of the University of Melbourne. The members are to hold office for a term of five years, and the Council is to elect its own President. A registrar is to be appointed for the purposes of the Act by the Governor in Council. He is to keep the medical register and perform such duties as the Medical Council may direct. Provision is made for the registration of duly qualified practitioners. In the third schedule to the Bill a list is provided of the recognized universities, colleges, and bodies; and any person possessing the qualifications of such bodies may be registered. The Council is empowered to add to this list or remove from it any names, or refuse to register any qualifications of any body whose course of study or examinations of students, in the opinion of the Council, have become insufficient to secure a proper amount of skill and knowledge. The Council has power to erase from the list the name of any medical practitioner convicted of felony or misdemeanour, or who has in consequence of any misconduct, professional or otherwise, been erased from the roll or list of graduates of any recognized body. In order to prevent unqualified persons practising, the Bill provides that any person who is not a registered medical practitioner, who pretends to be, or takes or uses the name of physician, bachelor, or doctor of medicine, licentiate in medicine, bachelor or master of surgery, licentiate in surgery, doctor, surgeon, medical, or general practitioner, or apothecary, or surgeon apothecary, or accoucheur, or licentiate, or practitioner in midwifery, or an oculist or aurist; who takes or uses any medical or surgical name, qualification, title, or description implying that he is a medical practitioner, or that he is recognized by law as a medical practitioner or member of the medical profession, shall be liable on conviction to a penalty of £50. Any medical practitioner whose name is erased thereupon ceases to be a legally qualified medical practitioner, and is liable to all the penalties imposed by the Bill on unregistered practitioners. Provision is made in the Bill under which coroners or justices may summon qualified medical witnesses, and penalties are imposed for neglecting to obey such summons. The Governor in Council may, under the Bill, grant licenses to practise anatomy, and may appoint an inspector of schools of anatomy, to give full information to the registrar-general of every subject used for purposes of anatomy, and inspect the places where anatomy is practised. Notice is to be given to the Minister of places where anatomy is about to be practised. Any infringement of the provisions of this part of the Act are to be deemed a misdemeanour, and to be punished with imprisonment or fine.

THE NEW MEDICAL BILL FOR NEW ZEALAND.

THE following letter has been received from the President of the Midland Pharmaceutical Association:—

No. 4, Victoria-street, Christchurch,
May 29, 1890.

DR. I. DE ZOUCHE,
Secretary, Medical Act.

DEAR SIR,—Your letter and papers of proposed Medical Act (for which thanks) were considered at last meeting of Midland Pharmaceutical Association.

It was decided by unanimous vote that there was nothing in proposed Act that would interfere with us in the ordinary course of our business. It was further resolved that we should give you any assistance that you might wish towards getting said Act passed in the House of Representatives.

I remain,

Yours truly,

(Signed) W. BARNETT,

President Midland Pharmaceutical Association.

This is the result of friendly discussion as to those clauses which, at first sight, might seem to be directed against what is understood as "counter practice." The Bill, however, does not introduce any change in the law regarding the practice of medicine; that is to say, there is no law by which any person can be prohibited from practising, nor is there any attempt in the Bill to make such a law. The clauses in dispute had reference to the unauthorized use of medical titles *for the purpose of practising*, and the rights of registered practitioners to sue for services, medicaments, and appliances.

The provisions of the new Bill, as to these matters, are almost identical with those in the Imperial Medical Act, and in the existing New Zealand Medical Registration Act. The whole Bill is as close a copy of the Imperial Medical Act as the circumstances of the colony will allow.

A SUCCESSFUL case of Cesarean section in which both mother and child were saved is reported in the quarterly number of the *New Zealand Medical Journal*, published in July. The operation was performed in the Otago Benevolent Institution, at Dunedin, the operator being Dr. Stenhouse. The patient was allowed to get up on the 21st day, "being then as fully well as a woman after a normal confinement." The special feature in the case is, we think, the commendable promptitude with which the operation was undertaken, instead of, as is too common in such cases, the patient being allowed to become exhausted before it is commenced.

THERE is also reported in the number of that same Journal a very notable case of removal of cerebral tumour, with complete recovery of the patient. The operator was Dr. Colquhoun, of Dunedin. The patient, a woman aged 42, suffered from fits and paralysis of the left side of the body. The diagnosis arrived at was that there existed a tumour of slow growth in the Rolandic area on the right side. The case was first seen by Dr. Colquhoun on January 26, 1890, the operation being performed on January 31; a trefoil shaped opening was made over the supposed site of the tumour by the removal of three pieces of bone with a three quarter inch trephine. Through this the growth, which probably had its origin in the dura mater, was removed, leaving a cavity three and a half inches in depth. The

fragments of the tumour weighed about five ounces' and a section taken from a part showed the characters of a small spindle celled sarcoma. She made an almost perfect recovery by the last week in May, having done her own washing and resumed control of her house. She has completely regained the use of her left side. She is still conscious of a little weakness in the left leg, but it is not discernible in walking. She had previously been subject to great mental disturbance with headaches, but has had no recurrence of either since her recovery.

THE MONTH.

NEW SOUTH WALES.

A RETURN to an address in the Legislative Council was laid upon the table of the House on July 16 by Mr. W. H. Suttor, in the shape of a letter with enclosures from Dr. G. T. Hankins, President of the New South Wales Branch of the British Medical Association, to the Colonial Secretary. The letter, which is dated April 18 last, brings under the notice of Sir Henry Parkes an article which appeared in the *Australasian Medical Gazette*, disclosing circumstances in connection with a certain person advertising himself as a doctor, which the letter points out "are of a startling character, and prove indisputably that the people of this colony, especially the more ignorant amongst them, are daily liable to become the victims of the many unscrupulous cheats irregularly practising medicine in it." Dr. Hankins states further that the Council of the Association has felt it to be its duty to direct him to communicate with Sir Henry on the subject, "not on account of any benefit that can arise to members of the medical profession, but because, from the facts which are being brought under the notice of its members, it is cognizant that the absence of a law properly regulating the practice of medicine in this colony is the cause of great injury, both physical and pecuniary, to the citizens residing in it." He therefore asks that consideration may be given to the question of the introduction of a Medical Bill during the then coming session of Parliament.

THE Government decided on July 14 that the completion of the Sydney Hospital buildings should be undertaken without any unnecessary delay.

It is proposed to establish a cottage hospital at Manly, a very favourite watering place nine miles N.E. of Sydney.

DURING the first six months of this year 360 cases of typhoid fever were admitted into the metropolitan hospitals of Sydney, 53 ending fatally, as compared with 619 admissions and 67 deaths in the corresponding period of last year.

DRS. F. N. MANNING, T. FIASCHI, and L. T. LAURE have presented busts of eminent medical men to adorn the corridors of the newly-erected Medical School Building of the Sydney University.

WE regret to have to record the death of Mr. George Proudfoot, M.B. et Ch.M., Edin., 1881, who died at Orange on July 28, at the early age of 31 years. Soon after his arrival in the colony, in January, 1882, he became Resident Medical Officer at the Sydney Hospital; he afterwards practised at Nyngan, and in March, 1885, he accompanied the N.S. Wales Contingent to the Soudan, as Assistant Surgeon. On his return he settled at Orange, where he held the appointment as Visiting Surgeon to the local hospital.

DR. H. T. BURY has been appointed one of the Resident Medical Officers of the Prince Alfred Hospital, Sydney, in the place of Dr. C. G. Wilson, who has left for Singapore as Medical Referee of the Equitable Life Assurance Society of New York.

DR. C. U. CARRUTHERS, of Balmain, has been appointed Visiting Surgeon to the Magazine Establishments, vice Dr. Evans, deceased.

DRS. EGAN and SCANLON have resigned their positions of Resident Medical Officers at the St. Vincent's Hospital, Sydney.

DR. J. P. KELLY, late of the Sydney Hospital, has gone to Casino, on the Richmond River, to take charge, for the next 18 months, of the practice of Mr. C. E. Crommelin, during the latter's absence in America.

DR. L. E. ROW, a native of Sydney, has been elected Medical Officer of the Grunfell Hospital, in the place of Dr. Boake, resigned.

DR. J. C. SOUTER, of Orange, has been appointed Visiting Medical Officer of the local hospital, in the place of Dr. Proudfoot, deceased.

DR. JAS. STRUTHERS, a recent arrival, has settled at Rylstone, 166 miles W. of Sydney.

DR. CHARLES SWANSTON, of Ashfield, and late of Mudgee, has been appointed an additional permanent Medical Officer to the Military Forces of the colony.

NEW ZEALAND.

DR. H. POLLEN has removed from Gisborne to Wellington.

DR. C. ROWLEY has removed from Bombay Settlement to Te Awamutu, 100 miles S. of Auckland.

DR. THOMAS, of Christchurch, has been elected President of the Canterbury Branch of the New Zealand Medical Association, for the year 1890-91; Drs. T. Guthrie and Irving, Vice-Presidents; Dr. Jennings, Secretary; and Dr. Deamer, Treasurer.

DR. C. E. THOMAS has commenced practice at Timaru, 100 miles S. of Christchurch.

DR. R. VOLOKMAN has removed from The Thames to East Oxford, 41 miles from Christchurch.

QUEENSLAND.

DR. W. R. BACOT has resigned his appointment as Resident Surgeon of the Hospital for Pacific Islanders at Geraldton.

DR. HY. ALEX. FRANCIS has commenced practice as a specialist in diseases of the throat, ear, and nose, at Wickham-terrace, Brisbane.

DR. E. J. B. MOHS has removed from Toowoomba to Laidley, 51 miles W. of Brisbane.

DR. F. S. PILKINGTON, surgeon on board the S.S. "Changsha," had a narrow escape from being drowned on July 26 by falling overboard, when the steamer was floated off the coral reef on the North Queensland coast; he was only rescued with some difficulty when he was just on the point of drowning. Dr. Pilkington arrived in Australia by the last trip of the ill-fated S.S. "Quetta."

SOUTH AUSTRALIA.

THE HON. J. H. ANGAS, M.L.C., has contributed the sum of £2,500 for the purpose of building and furnishing a new wing to the Home for Incurables, near Adelaide.

DR. E. W. MORRIS, a new arrival, has commenced practice at Port Adelaide.

TASMANIA.

THE late Mr. Arthur Leek, of Ashly, near Ross, has bequeathed £1,000 each to the hospitals at Hobart, Launceston, and Campbelltown.

DR. W. A. HARRISON, of Strahan, has been appointed a Justice of the Peace.

VICTORIA.

THE Council of the Melbourne University has appointed the following additional Examiners for the ensuing year:—Descriptive and Surgical Anatomy, and Regional and Applied Anatomy, Mr. G. A. Syme and Mr. F. D. Bird; Pathology, Dr. Moore and Dr. Maudsley; Theory and Practice of Medicine, Dr. Maudsley.

At a recent meeting of the Charities Commission, Dr. J. H. Webb stated that five House Surgeons of the Melbourne Hospital had died of phthisis, contracted in the institution through the insanitary condition of their quarters.

THE Medical Superintendent of the Melbourne Hospital states that during the 12 months ended June 30, 720 cases had to be refused admission from want of room, though a great number of these were subsequently admitted. The number of patients suffering from typhoid fever treated during the same period amounted to 428, of which 70 died, or about 17 per cent.; of diphtheria, 70 cases were admitted, all severe, the majority being laryngeal cases, and the death-rate in consequence is high—42 or 60 per cent.; of phthisis, 262 cases were admitted, of which 153 died. Erysipelas—admitted, 75, of which two died; developed, seven, of which none died. Pyæmia—admitted three; developed, one, all of which died.

THE total number of attendances of patients at the Victoria Ear and Eye Hospital for the year ended June 30 was 22,934, being only a slight increase, but the actual number of new distinct cases treated, which was the standard to judge by, was 3,930 as against 3,559 last year, being an increase of 371, or 10½ per cent. The number of in-patients admitted during the year was 373, and the operations performed on both in and out patients numbered 897 as compared with 872 last year.

THE annual report of the Committee of the Austin Hospital for Incurables makes special mention of the services of Dr. W. McCrea, who has been President of the institution since its foundation till last year, when he retired.

At a special meeting of the Geelong Hospital Committee, held on July 23, Dr. P. A. Croker, after serving for more than 10 years on the honorary medical staff, was appointed an Honorary Consulting Medical Officer, a position similar to that occupied in connection with the institution by Dr. D. B. Reid.

DR. W. B. BOYD, late Resident Surgeon of the Melbourne Hospital, has succeeded to the practice of Dr. L. F. Praagst, at Hoddle-street, East Melbourne.

DR. S. MANNINGTON CAFFYN, of Middle Brighton, has returned to the colony from his trip to England by the S.S. "Port Adelaide."

DR. W. M. CLAYTON, late Resident Medical Officer Women's Hospital, Melbourne, has commenced practice in Burwood-road, Hawthorn.

DR. M. CRIVELLI has returned from his trip to France and resumed practice at Albert Park, South Melbourne.

SURGEON-MAJOR G. H. FETHERSTON has been promoted to be Brigade Surgeon of the Naval and Military forces in Victoria, vice Dr. J. Fulton, who has been placed on the retired list.

MR. T. N. FITZGERALD, F.R.C.S.I., of Melbourne, was presented, on July 24, with an illuminated address and a portrait of himself in oil, by the members of the medical profession in recognition of his skill as a surgeon, and also of the able manner in which he fulfilled his duties as President of the Intercolonial Medical Congress which was held in Melbourne last year. Mr. Fitzgerald, in acknowledging the testimonial, stated that the success of the Congress was due to the ready assistance which had been given on all sides, and he mentioned that the report of its proceedings had attracted much attention in Europe and America. He expressed a hope that every effort would be made to secure the success of the next session, which is to be held in Sydney.

THE HON. DR. G. LE FEVRE has been appointed a member of the Dental Board of Victoria, in the place of Dr. R. F. Hudson, resigned.

DR. W. H. STOCK has removed from South Yarra to Yea, 80 miles N.E. of Melbourne.

MEDICAL APPOINTMENTS.

Angove, William Thomas, M.R.C.S. Eng., to be a Surgeon to the South Australian Military Forces.
Canny, Denis Joseph, L.R.C.P. Ed., M.R.C.S.E., to be a Public Vaccinator in South Australia.
Chapple, William Allan, M.B., to be a Public Vaccinator for the district of Motueka, N.Z.
Ewart, John, M.D. & Ch. M. Ed., to be an additional Public Vaccinator for the district of Wellington, N.Z.
Gillespie, William, F.R.C.S. Ed., L.R.C.P. Ed., to be Public Vaccinator at Swan Hill, Vic., vice Dr. R. L. McAdam, resigned.
Howlin, James, L.F.P.S. Glas., L.K.Q.C.P. Irel., to be Government Medical Officer at Dalby, Qu.
Martell, Horatio Peroy M.B. Melb, to be a Public Vaccinator for Carlton, Vic., vice Dr. W. M. Clayton, resigned.
Martin, Robert, L.F.P.S. Glas., L.R.C.P. Ed., to be an additional Public Vaccinator for the district of Dunedin, N.Z.
Mohs, Ernest Johann Rudolph M.D. & Ch. D. Berl., to be Government Medical Officer at Ladley, Qu.
Parkinson, Charles Joseph, M.B. Lond., M.R.C.S.E., to be Public Vaccinator at Malvern, Vic.
Smith, Robert, L.R.C.S. Irel., to be Public Vaccinator at Drouin, Vic., vice Dr. D. Trumphy, resigned.
Stewart, J. A., M.B., to be a Public Vaccinator in South Australia.
Stock, William Henry, L.F.P.S. Glas., L.K.Q.C.P. Irel., to be Public Vaccinator for the district of Yea, Vic., vice Dr. E. J. Lock, resigned.

BIRTHS, MARRIAGES, AND DEATHS.

* * The charge for inserting announcements of Births, Marriages, and Deaths is 2s. 6d., which should be forwarded in stamps with the announcement.

BIRTHS.

ARMSTRONG.—July 28, at Merriwa, N.S.W., the wife of William George Armstrong, M.B., of a daughter.
BOWMAN.—July 17, at Singleton, N.S.W., the wife of Dr. Allister Stewart Bowman, of a son.
DIXON.—July 14, at Elizabeth-street, Sydney, the wife of Thomas Dixon, M.B. C.M., of a daughter.
ELPHICK.—On the 18th July, the wife of Edward Elphick, L.R.C.P., Prospect North, S.A., of a son.
HOWARD.—On the 14th July, at North Fitzroy, Melbourne, the wife of D. T. Howard, M.D., of a son.
LOOSLI.—On the 11th July, at Camberwell, Vic., the wife of Dr. K. J. Loosli, of a daughter.
NASH.—On July 1, at Wallsend, N. S. W., the wife of Dr. Nash, of a daughter.

DEATHS.

BOWSER.—On the 1st August, at Footscray, Melbourne, Isabella Annette, the wife of Dr. H. C. Bowser, aged 60 years.
SINCLAIR.—On July 21, at Gladesville, N. S. W., Eliza, wife of Eric Sinclair, M.D.

REPORTED MORTALITY FOR THE MONTH OF JUNE, 1890.

Cities and Districts.	Population.	Births Registered.	Deaths Registered.	Deaths under Five Years.	Number of Deaths from									
					Measles.	Scarlet Fever.	Croup and Diphtheria.	Whooping Cough.	Typhoid Fever.	Dysentery and Diarrhoea.	Phthisis.	Heart Disease.	Cancer.	Child-bearing.
N. S. WALES.														
Sydney	128,880	306	142	48	...	1	2	...	2	3	20	10	3	1
Suburbs	252,860	776	271	92	...	1	2	...	2	3	20	10	3	1
NEW ZEALAND.														
Auckland	33,307	67	35	7	...	1	...	...	2	1	4	4	3	1
Christchurch	17,116	32	17	5	...	...	1	1	...	...	2	5	...	...
Dunedin	24,168	52	25	1	...	...	...	...	5	...	1	3	3	...
Wellington	31,028	87	35	8	...	3	...	...	4	1	7	1	2	...
QUEENSLAND.														
Brisbane	51,689	205	83	34	}	...	2	13	1	10	19	4	2	1
Suburbs	21,960	166	35	16										
SOUTH AUSTRALIA.														
Adelaide	319,604	915	344	121	...	...	24	11	5	9	26	29	8	6
Adelaide	44,581	92	84	21	...	...	...	5	1	1	13	5	2	4
TASMANIA.														
Hobart	35,889	72	47	16	...	...	1	...	...	...	2	8	4	1
Launceston	22,075	68	25	14	...	...	4	2	...	...	3	...	2	...
Country Districts	94,639	234	85	...	...	1	1	3	2	4	...	...	...	1
VICTORIA.														
Melbourne	75,400	173	81	} 218	...	6	55	2	20	7	68	50	21	12
Suburbs	362,365	1,502	570											

METEOROLOGICAL OBSERVATIONS FOR JUNE, 1890.

STATIONS.	THERMOMETER.				Mean Height of Barometer.	RAIN.		Mean Humidity.	Prevailing Wind.
	Maximum Sun.	Maximum Shade.	Mean Shade.	Minimum Shade.		Depth.	Days.		
						Inches			
Adelaide—Lat. 34° 55' 33" S.; Long. 138° 36' E. ....	...	67·8	55·6	39·6	29·858	...	...	...	...
Auckland—Lat. 36° 50' 1" S.; Long. 174° 49' 2" E.	116·	65·	55·7	44·	...	3·740	16	79	...
Brisbane—Lat. 27° 28' 3" S.; Long. 153° 16' 15" E.	126·5	76·1	60·4	50·1	30·040	0·917	9	75	...
Christchurch—Lat. 43° 32' 16" S.; Long. 172° 38' 59" E.	113·	68·6	44·3	27·	...	1·515	11	77	...
Dunedin—Lat. 45° 52' 11" S.; Long. 170° 31' 11" E.	97·	62·	43·7	32·	...	0·512	11	84	...
Hobart—Lat. 42° 53' 32" S.; Long. 147° 22' 20" E. ....	...	62·6	50·	35·8	29·930	5·37	24	92	...
Launceston—Lat. 41° 30' S.; Long. 147° 14' E. ....	...	65·	51·4	31·	29·943	6·28	19	89	...
Melbourne—Lat. 37° 49' 54" S.; Long. 144° 58' 42" E. ....	...	66·	53·	38·	29·899	1·71	13	...	...
Sydney—Lat. 33° 51' 41" S.; Long. 151° 11' 49" E. ....	...	69·2	57·2	45·4	29·925	10·78	19	80	...
Wellington—Lat. 41° 16' 25" S.; Long. 174° 47' 25" E.	105·	63·	50·5	37·3	...	2·282	18	79	...

AUSTRALASIAN MEDICAL GAZETTE.

ORIGINAL ARTICLES.

GASTRO-ENTEROSTOMY BY MEANS OF SENN'S DECALCIFIED BONE PLATES FOR CANCER OF THE STOMACH.

By J. W. HESTER, M.B., CH.M., SYD., MEDICAL SUPERINTENDENT NEWCASTLE (N.S.W.) HOSPITAL.

P. J., aged 36, a seaman by occupation and a Finn by nationality, was admitted to the Newcastle hospital on June 16th, 1890, complaining of vomiting, and some slight pain in the epigastrium.

Briefly his history was as follows: Four months before admission patient noticed that he vomited every two or three days, generally at night. He had no pain. This continued for about two months, when the vomiting became more frequent and he felt some pain in the epigastrium, not continuous, but worst when vomiting. He found that he was losing weight rapidly, and on one or two occasions had passed black stools and vomited coffee grounds.

Previous History.—Was always very healthy and did not suffer from dyspepsia. Did not drink heavily and had no specific history. The last time he weighed, about a year previous to admission, he turned the scale at 13 stone. No family history of cancer.

On admission patient was found to be a tall slender man, weighing $9\frac{1}{2}$ stone. All his organs were healthy, with the exception of the stomach, which was very much dilated. Nothing could be felt by abdominal palpation. After treatment by gastric sedatives for a few days stomach was washed out. A fortnight later, on careful examination, an indistinct tumour was felt in the right epigastric region. Two days later a consultation of the staff was called and the patient anesthetized for examination. The anæsthetic being very badly borne had to be stopped before much information could be gained. A few days later he was immersed in a hot bath, and the tissues being thoroughly relaxed a distinct hard lump was felt in the right epigastric region. It moved freely up and down on respiration, and seemed to be about three inches in length and one in breadth, lying transversely. Vomiting still continuing, in spite of daily cleansing of stomach with boracic lotion through a soft syphon tube, an exploratory laparotomy was proposed to the patient, a suggestion in which he readily acquiesced.

At this time very little food, if any, passed the pylorus, and from the man's enfeebled condition the operation of pylorotomy was held by the staff to be absolutely out of the question, and Dr. Jessett's operation of gastro-enterostomy by means of Senn's plates (as reported in the *British Medical Journal* of July 27th, 1889) was proposed as the only alternative. Some bone plates were kindly supplied from the Prince Alfred Hospital, but they were crushed in transmission, and I made my own from ox scapulae. These were a fortnight in preparation, and during that time the patient's stomach was daily washed with boracic acid lotion, and he was allowed a little peptonized milk, plenty of raw beef juice, beef tea, and a little meat, receiving also at the same time four nutrient enemata daily. Under this treatment his weight remained uniformly at 9st. 4 lbs.

On the afternoon of July 28, his stomach having been twice washed out during the morning, and the obstruction at the pylorus being now complete, I, with the assistance of Drs. Harris, Beeston, and Eames, performed laparotomy by means of an oblique incision four and a half inches in length, midway between the ensiform cartilage and the umbilicus, two-thirds of the incision being on the right side of the linea alba. A very large mass was then felt, involving the lower end of the stomach. After some search the first part of the jejunum and stomach were brought out through the wound, incisions made, bone plates slipped into position, brought into apposition, and corresponding threads tied. The parts having been well washed with boracic lotion, and the surrounding boracic towels removed, the viscera were then dropped back into the abdominal cavity and the wound closed and dressed. Patient was put to bed in the same room, near a good fire, and though the pulse was very feeble on completion of the operation, which lasted altogether a little over an hour from the first incision till the dressings were finished, he rallied during the night and spoke a little. He was fed entirely by nutrient supportories (zymine) alternating with nutrient enemata every three hours, but the temperature remained subnormal, pulse very quick and weak, and he died $25\frac{1}{2}$ hours after the operation.

Post-mortem.—Parts in good apposition, and lymph thrown out between opposed surfaces. Good patent canal between stomach and jejunum. The portion of intestine which had been exposed was congested, but there was no peritonitis. The stomach was found very greatly dilated, with thickened walls, and the lower third was completely infiltrated by a mass resembling encephaloid

cancer. This encircled the lower end of the stomach completely for about four inches, extending further along the lesser curvature and posterior wall than elsewhere. The passage to the duodenum was completely occluded by the mass which ended abruptly at the pylorus. There was a small area of ulceration at the upper end. The serous surface was unaltered.

Dimensions of Stomach.—Along great curvature 24 inches; along lesser curvature 10 inches. **Dimensions of Mass.**—Along great curve 4 inches; along lesser curve $4\frac{1}{2}$ inches.

Microscopically.—Tumour proved to be encephaloid cancer.

Remarks.—The comparative youth of the patient, and rapid progress of the disease are remarkable. With reference to the operation itself, the two points of greatest difficulty which presented themselves were—(1). The finding of the first part of the jejunum with as little manipulation as possible. (2). The keeping of plates in apposition whilst corresponding threads were tied. In this connection I should like to urge very strongly that silk be used for threads and not gut, as everything depends on the plates being well brought together, and by using the latter, the risk of breaking in the endeavour to bring the parts into good apposition is by no means inconsiderable.

ON ICHTHYOL AND ITS USE IN MEDICINE AND SURGERY.

By A. MUELLER, M.D., OF YACKANDANDAH, VICTORIA.

THE valuable remedy I herewith propose to bring under the notice of my Australian colleagues, though introduced into the German medical practice by Unna, in 1883, and since then admitted into the German Pharmacopœia, appears to be but little known as yet to English practitioners. As its uses are manifold, and its beneficial effects, especially in certain hitherto intractable forms of disease, far superior to anything previously employed to combat with them, my desire to procure for the remedy a more extended use in Australia needs no apology.

Ichthyol is obtained by distillation from a bituminous mineral, containing large quantities of fossil-fish, hence the name given to it. The raw oil is then treated with concentrated sulphuric acid, in certain proportions, and the mixture neutralized either with potassium sodium, ammo-

nicum, or lithium, the result being either one or the other of the preparations in use in Germany under the names of kalium, natrium, ammonium, and lithium sulpho-ichthyolicum, rather long-winded appellations, which in English might be shortened into potassium, sodium, &c., ichthyolate. According to Professor Bauman and Dr. Schotten, the raw oil contains: carbon, 77.25; sulphur, 10.72; hydrogen, 10.52; nitrogen, 1.10. The analysis of sodium ichthyolate gives, carbon, 55.05; hydrogen, 6.06; sulphur, 15.27; sodium, 7.78; oxygen, 15.83. All these preparations are soluble in water, the solutions, however, being cloudy and making a slight resinous sediment. Perfect solution is effected only in a mixture of alcohol and ether, but for all practical purposes the solution in water suffices. The Ichthyol-Gesellschaft, Cordes, Hermann and Co., Hamburg, are the sole manufacturers. As it is not very prepossessing either in odour or in taste, it is supplied for internal use in form of pills (sugar-coated), and capsules, most elegantly got up in watertight enamelled tin boxes. For lotions, ointments, &c., it is supplied in tins of various sizes, faultless in form. The firm likewise supplies ichthyol plaster and ichthyol lint, for the dressing of wounds, and likely to be largely used in military practice.

The therapeutic effect of ichthyol must be ascribed to a peculiar close combination between sulphur and carbon, introducing both elements into the system in a pure, and at the same time, soluble form. They consist, briefly stated, in a contraction of congested and abnormally distended capillaries. Wherever such congestion and consequent distention exists, be it active or passive, the beneficial action of ichthyol becomes almost immediately manifest. It is only by bearing this in mind, and by considering capillary congestion in one form or the other one as accompanying the most heterogeneous diseases, in fact, as frequently being the disease we have to treat, that we can understand the efficacy of ichthyol against numerous affections that have no relation whatever to each other, and between which, barring the congestion of capillaries, it would be difficult to find a single feature of similarity or analogy.

In giving some of my own experiences with the remedy, I should be afraid of appearing in the light of a medical Münchhausen, or worse still, in that of a quack, recommending a universal remedy for all the ills human flesh is heir to, if these experiences were not backed up, and had not been surpassed by men of European fame, such as Unna and von Hebra, the great dermatologists, Professor Schweniger and Ziegler, of Berlin, von Nussbaum, of Munich, Drs. Acherman-Weimar,

Lorenz, and many others both in and out of Germany.

As will be anticipated from the foregoing statements, ichthyol is a capital remedy in skin diseases, and its applicability extends over the whole range of them, from simple roseola and eczema up to psoriasis and lepra. It combines excellently with simple ointment, lard, and especially with lanolin, and I prescribe it in from 5% to 15 and 20% proportions, at the same time giving it internally in doses of from 3 to 10, 12 and 15 pills, or a corresponding number of capsules, and reducing the doses or suspending the use of the drug for a time, when it begins to cause diarrhoea, which with many patients does not occur at all. There is not the least discomfort accompanying its internal administration; on the contrary, the appetite, with very rare exceptions, is stimulated, and the *patient gains in weight*. With regard to the external use of the drug, either in form of lotion or ointment, it is necessary to observe that its resinous ingredients coat the skin and make it sticky, and that to ensure the greatest possible efficacy the parts must be washed every night with warm water and soap, and if the area of disease is not too extended, rolled up in ichthyol wadding. In illustration a few cases:—

J. B., a farmer, *æt.* 60, who had repeatedly consulted me on account of enormous varicosity of both legs, was brought in from the country with one of them greatly swollen and extremely painful, thickly covered with eczema and having, moreover, two ulcers over the tibia of the size of a sixpence each, apparently in rapid course of enlargement. As he had had repeated rigors, and his temperature was over 100°, I was afraid of phlebitis and abscess, and therefore applied immediately four dozen leeches, to be followed by bathing in warm water and a stiff linseed meal poultice. Though the bleeding was profuse, and the swelling slightly reduced, the leg, on the following morning, was still extremely painful, and could not be moved in bed by patient himself, whilst my handling it caused him to sing out. A soft elastic cotton bandage was now soaked in a 15% ichthyol lotion, and applied as tightly to the leg as patient could bear. The leg was placed on gutta-percha and a pillow outside the blankets, and directions were given to keep the bandage constantly wet with the lotion, and after wetting it roll the gutta-percha round it. The improvement which was effected by this treatment within 24 hours was truly marvellous when compared with any other mode that could have been adopted. To my own and the patient's surprise the violent pain was all but gone, the swelling greatly reduced, and the angry bluish colour of the eczema had changed to a faint red. In spite

of the latter the skin had become wrinkly, and was discharging a clear watery liquid. When, on the third day after commencing the ichthyol treatment, I went to see my patient I found him up, dressed, and able to walk about with the aid of a stick. He left for home on the fourth day, directed to walk as little as possible, keep the leg well bandaged in a horizontal position, and anoint it twice a day with a 10% ichthyol ointment. I heard no more of him, but saw him again about a month after he had left. The eczema, sometimes so troublesome in such cases, was completely cured, the ulcers had healed, and the leg was sounder than it had been for years.

Some months ago I attended Mrs. C., *æt.* 54, suffering from that odious affection, pruritus pudendorum. Alternatives internally and local applications of strong hydrocyanic acid ointments with morphia, and finally with cocaine, gave but temporary relief. The poor woman suffered agonies, especially at night, and at each visit overwhelmed me with supplications for a more speedy cure and descriptions of her sufferings. She had the fixed idea that a neighbour with whom she had quarrelled, and who had expressed the pious wish that she might never have a day's health, had been instrumental in causing her affliction. By a strange coincidence, or the "stern Nemesis of fate," this neighbour, a Mrs. L., was overtaken by the same complaint, and I thus had two unfortunates on my hands whom to treat was by no means an unmixed pleasure. Casting about for some other remedy more efficient than those already tried with but indifferent success I fell back on ichthyol, and determined to give it a fair and full trial. I gave it internally in large doses, had the parts well anointed with a 5% ointment, and ordered a warm hip bath to be taken every night at bed-time. Under this treatment, continued for a fortnight, a gradual but steady improvement took place, and both unfortunates were cured simultaneously.

Mr. K., *æt.* 70, had suffered for some years from what he thought to be the itch, but which on examination I found to be prurigo. It troubled him especially at the turn of the seasons, in spring and autumn, and as the itching all over the body was then almost unbearable his health, owing to want of sleep, became seriously impaired. He had been under treatment several times, and only sent for me as a last resource, scarcely expecting that I would give him any relief. I put him under the ichthyol treatment, with warm baths at bed-time, and on the very first night after using the ointment he was able to sleep several hours. The itching, and with it the eruption, disappeared gradually within a fortnight.

In lesions of the skin by heat, both burns and scalds, ichthyol is likewise superior to any other remedy I know of. It does not prevent blistering, and is rather severe at first when applied to the raw surface, but the addition of a little pulv. opii. to a 10% ointment does away with this objectionable feature. The wounds require dressing far less frequently, whilst the new skin grows with surprising rapidity. I have quite lately treated a case of extensive burns, caused by the explosion of a kerosene lamp. Both hands, a great part of the face, the neck, chest, including breasts, and the upper part of the abdomen were one raw surface when I was called in by Mrs. P., five days after the occurrence. I dressed the parts at once with an 8% ichthyol ointment, to which subsequently, as it burned rather much, some pulv. opii. was added. In less than three weeks the whole of this large surface was skinned over again with the exception of the left breast, of which a large flap of skin had sloughed away entirely.

Where the skin and the subcutaneous cellular tissue are both congested, the striking effects of the ichthyol, locally applied, are still more manifest. This is especially the case in erysipelas. Very soon after local application the swelling begins to subside, the skin becomes wrinkled and emits watery liquid through the pores, as in perspiration. At the same time the disease becomes stationary, and makes no further encroachments on healthy tissue. Ichthyol internally or, if necessary, some other medication, must of course accompany the local treatment.

That in traumatic erysipelas and in malignant, phlegmonous cellulitis the action of the drug is equally beneficial in arresting the progress of the disease and rendering the absorbed poison apparently innocuous, will probably provoke an incredulous smile with most readers, yet the testimony of my countrymen at home, and my own experience, place this gratifying fact beyond all doubt. I have also used the remedy in two cases of carbuncle with the effect of greatly reducing the area of inflamed tissue, relieving the pain, and converting the hard, bluish centre, apparently on the point of mortifying, into a mere futruncle. I use strong lotions and ointments containing from 25% to 50% of ichthyol in such cases, and in very bad ones should apply the drug pure. It is hardly necessary to state that inflammatory swellings arising from contusions, sprains, fractures and dislocations are both prevented and cured by ichthyol. It becomes to a surgeon who has once adopted it an absolutely indispensable remedy.

The most pronounced success, however, this new addition to our *materia medica* has achieved is in the treatment of rheumatism and gout.

The effect of a 25 per cent. ointment on a painful, swollen and immovable joint must be seen to be believed. Pain and swelling frequently disappear in less than twenty-four hours and movability is restored. In chronic rheumatism only the local treatment is frequently sufficient, in acute it might not be safe to trust to it alone. Still more unique, though less rapid is its efficacy in gout, especially in that intractable form known as arthritis deformans.

Here I can speak from my own recent and personal experience. For some years past I had suffered from stiffness and soreness in both hip joints, preventing me from walking any distance; but as one of them had been dislocated many years ago and I had done all my travelling in a large mountainous district for over thirty years on horseback, I attributed the stiffness to these antecedents, not suspecting actual disease, until I became quite unable to walk up a steep hill or a flight of steps, and the joints began to emit a suspicious cracking noise. When at the same time the knuckles of my thumbs and other finger joints began to get painful and enlarged visibly, the diagnosis of arthritis deformans was unavoidable, and the insidious enemy had to be met and conquered if possible, or at all events prevented from further encroachments. After revising the dietary scale and reducing my allowances of meat and wine to a minimum, I commenced taking ichthyol pills, from three up to twelve and fifteen, twice a day. I have now taken the remedy for a month, and though I do not flatter myself to be cured, the improvement it has produced is a marked one. I can walk and mount my horse without pain, and the enlarged knuckles have become pale and are quite free from tenderness on pressure. Another effect, showing that the remedy has gone to the root of the mischief, is the absence of an uncomfortable tenderness in the liver. I had felt this for years and could only remove it for a time by stimulating the bile secretion. Now I am almost free from it, and can look over my right shoulder without feeling that I have a liver. One of the chief advantages of the remedy is the total absence of all discomfort under a prolonged use. Its presence in the stomach is only felt by an increased appetite. It stimulates the action of the liver and of the bowels, and for abdominal engorgement is no doubt *the remedy par excellence*. Its action on the portal circulation is similar to that of sulphur, but much more intensified, for the peculiar combination of sulphur and carbon, to which its efficacy must be ascribed, is perfectly soluble, and enables us to saturate the system with sulphur, of which, when administered in substance only a very small portion can enter the circulation. In

removing passive congestion of the abdominal organs, so apt to occur in our climate, and in thus stimulating the sluggish portal circulation, ichthyol sweeps that Augean stable, from which so much discomfort and disease is apt to arise, and its stimulating, vitalizing and quasi rejuvenating effects on the system can only thus be explained. Among these effects, however, is one which must finally be mentioned, if only by way of caution to bachelors and widowers. Ichthyol stimulates the genital organs and engenders desires which it might be inconvenient, and with old people, after Brown-Séquard's researches, unwise to satisfy.

CASE OF COMPLETE ABSENCE OF VAGINA.

OPERATED UPON BY H. C. GARDE, F.R.C.S.,
SURGEON TO THE MARYBOROUGH HOSPITAL,
QUEENSLAND.

MR. C——, a sugar planter on the Mary River, called upon me early in May last to obtain advice re a young Kanaka woman whom he had in his employ during the few months previous, and who suffered so severely for about eight or ten days in each month as to unfit her for work. From what the husband of the woman was able to tell him, he came to the conclusion that there was something wrong with the genital organs, and it was on that account chiefly that he, the husband, came back to Queensland to try and get medical advice for her, none being obtainable at the island where he lived; the boy could speak English, having worked here before, but his wife could not, so that they could not make out much beyond that she suffered severe pains in the abdomen and back at the times before stated. She was sent into hospital a few days after for examination and treatment.

She was of medium size and slight build, apparently about sixteen or seventeen years of age—the Islanders get married early as a rule—the breasts were well developed and so were the external genital organs. On attempting to introduce the finger into the vagina I was "brought up with a round turn," and on separating the labia, only a slight depression or "cul-de-sac" could be seen. There was a tumour about the size of a small orange in the hypogastric region just above the pubis. On bimanual examination, two fingers of the left hand in the rectum, the tumour was found to be moveable and something like the cervix was made out; a sound was then passed into the bladder and what perhaps might be termed the vesico-rectal septum could be traced from the depression upwards for

a distance of about three inches, where it expanded into the enlargement. As the results of leaving such cases alone are almost necessarily fatal, it was determined to try and make an artificial vagina. Accordingly, on May 18th, she was put under chloroform and placed in the lithotomy position; the bowels and bladder having been previously acted upon, the labia were held apart and a transverse incision made into the septum, the index finger being in the rectum and a sound held in the bladder by an assistant; and then commenced what proved to be a tedious and tiresome operation, the septum was of a very tough nature and took a lot of breaking down, the finger and handle of scalpel being mostly used, but frequent recourse had to be made to the knife. After opening up the parts to the extent of two inches, I next passed a No. 4 needle of an aspirator slowly and with caution, to a further distance of an inch or so, when a few drops of thick dark fluid began to appear—the needle was held tightly in position, it seemed to be gripped, and would have taken a good pull to have withdrawn it; a tenotomy knife was passed along the needle, one side incised slightly, withdrawn, reinserted, and the other side incised to a similar extent; the knife was then withdrawn and a long probe passed alongside the needle and the latter withdrawn, then with a pair of dilating forceps I proceeded to forcibly dilate the passage, which was done gradually, and when the tumour was reached about two ounces of dark treacly fluid flowed out. The index finger was inserted, the new vagina admitting it freely; the os felt normal, giving one the idea that the fluid had accumulated around the cervix and a little below it, and had pushed the uterus upwards. Carbolyzed water was used to syringe out the canal, and strips of lint squeezed out of carbolyzed oil were inserted to keep the raw surfaces apart. The patient was a regular savage and was difficult to manage, although kept under lock and key she would not stay in bed, and in fact never lay up for a day. While she remained in hospital the same treatment was carried out, viz., syringing and carbolyzed plugging. On June 12th she menstruated without pain, and was taken back by her employer on June 17. She then had a useful vagina, but the probability is that it will contract in the course of time, it being impossible to have anything like treatment carried out on the plantation. I had not Sims' glass vaginal plugs, so had to do the best I could; and even if they were at hand it is doubtful if she would retain them. The operation as far as possible was carried out on the lines laid down by Dupuytren and Amussat.

Maryborough, Queensland,
August 26, 1890.

CASE OF PUERPERAL ECLAMPSIA.

By SINCLAIR FINLAY, L.R.C.S.I., L.K.Q.C.P.I.,
OF STROUD, NEW SOUTH WALES.

THE following case may be of interest to your readers. On Sunday, July 6th, I was summoned at 7 a.m. to go 15 miles to see R. E., age 19 years, unmarried, who the messenger told me had been confined at 4 a.m., and since then had been unconscious and in convulsions.

I arrived at the house at 9 a.m., and learned the following particulars:—She (R. E.) was taken ill at 12 p.m., and at 2 a.m. the midwife arrived, who informed me that from her arrival the girl had never spoken or answered her questions, nor could she tell when the labour pains were on; at 4 a.m. the child was born alive, and as the head passed the vulva the first fit took place; from that time until my arrival she had nine convulsive seizures, the last two being only five minutes apart; it took three to hold her when in them. I learned that she had always enjoyed good health, but that for the past three days she had been suffering from La Grippe. Having found that the after-birth was entirely away, and that the bowels had recently been opened, I gave an enema of 40 grs. of chloral and 40 grs. of bromide of potash; in 15 minutes she had another very strong seizure, so I gave another similar enema with $\frac{1}{2}$ gr. morphia, hypodermically; it was 45 minutes before she had another, and then one in 15 minutes, so I again gave an enema containing the same amount of the drugs, and the same of morphia; she had no more for two hours, and then it was not so severe. I now gave the morphia alone, and as there was seven hours before the next I thought I would wait before giving any more medicine, but gave an enema of plain soap and water with a little castor oil added; this, however, did not act.

I waited at the house all night, and at 8 a.m. next day (Monday), as there were no signs of any more fits, I thought I might leave, having left instructions with the nurse to pass a catheter at 4 p.m., and give a simple enema. I also ordered her to be fed by the rectum, as it was impossible to get her to swallow anything.

I did not see her again, but heard from her brother that she remained unconscious until Wednesday evening at 8 p.m. Since then she has made a good recovery.

I think this case of interest: from the length of time she was unconscious, 88 hours, and from her having just recovered from an attack of La Grippe; could the latter have anything to do with her illness?

ON SPONTANEOUS VERSION.

READ BEFORE THE NEWCASTLE (N.S.W.) MEDICAL
SOCIETY.

By C. W. MORGAN, M.D., L.R.C.P. (LOND.)

THE term spontaneous evolution was first used by Denman to denote a process of delivery by which nature relieved herself in cases of shoulder presentation, when mechanical version had not been accomplished. Dr. Denman's theory was that the shoulder did not maintain its position in the pelvis, but moved upwards during the continuance of the pains, towards the brim, on that side which the head originally occupied, the head itself moving in a corresponding direction in the (opposite) iliac fossa. This ultimately made room for the nates which descended towards the floor of the pelvis when labour terminated, as if the case had been from the first a presentation of the breech. Since then Douglas of Dublin described another process in which the shoulder, instead of ascending, continues to descend till it becomes fixed against the subpubic arch when it is arrested, and forms a centre on which the body of the child revolves.

In this case the breech must pass the pelvic brim already partly occupied by the base of the skull, which would seem almost an impossibility. Such cases have, however, been recorded; the thorax, buttocks, and remaining shoulder succeeding each other in their passage over the distended perineum.

To such a process Douglas gave the name of spontaneous delivery, but more modern writers, among whom is Playfair, call Denman's process spontaneous version, and Douglas' spontaneous evolution. With the permission of the society I will alter the title of my paper, which purported to be on Spontaneous Evolution to that of Spontaneous Version, which I think is the more correct term to employ.

The cases I shall relate occurred at different periods of my past practice, the most recent being 22 years ago, and I have still notes taken at the time from which I have prepared the present paper; nevertheless, the spirit of unbelief being active in these latter days, I would ask gentlemen to be indulgent: Spontaneous version is harder to swallow than convulsions that have no physiological right to interfere with diagnosis, and a gentle cough, even if heard in chorus, will be accepted by me at its intended significance!

Case 1.—Newcastle, September, 1862.—Mrs. P.B., 32, a woman of splendid physique, fourth labour. I had attended her in confinement about

18 months previously; on which occasion her labour was so rapid, and the uterine contractions so violent, that but two expulsive pains occurred. The first impelled her to rush from her fireside, where she was occupied in cooking, to her bedroom; the second seized her as she was stepping into bed, and the child was expelled on to the floor, breaking the funis by its sudden weight. With such a patient labor was always sharp, short, and decisive.

When the message reached me I was leaving my house in Wolf-street, and my horse was in waiting at the door. I galloped down to one of the old huts still extant near the Carrington crossing, in Blane-street. We rode in those days, and a very few minutes brought me to Mrs. B.'s door. Labour had advanced to the last stage, and the expulsive pains were the most severe I ever witnessed. On examination, I found the shoulder presenting and tightly wedged into the pelvis; the right arm extruding, the head at the brim, with the occiput towards the right iliac fossa. The uterine contractions were so terrible that I feared rupture would take place, and jumping on my horse, I rode at a gallop back to my house for chloroform—my absence could not have been more than 15 minutes at the outside.

On my return I found labour just completed by natural process. The child was born as I entered the door, and was lying in the bed. The feet had evidently been expelled first, the head had hardly left the vagina, and the right hand and arm, swollen and turgid, were lying by the side of the head, extended upwards, as if they had passed together with it. The duration of this woman's labour could not have exceeded an hour, and the spontaneous nature of the delivery was caused by the violence of the uterine action. It is advanced by Caseaux and others that spontaneous version is produced by partial or irregular contraction of the uterus, one side contracting energetically while the other remains inert, or only contracts to a slight degree. The mechanism of the case in question is plain to me: the uterus endeavoured by all forcible means to expel the fetus, and failing, by contraction of the longitudinal fibres, to expel directly, a combination of forces from left to right took place by which the head and back were made violently to sweep the cavity of the womb, revolving with such force that the nates and feet took the place of the shoulder, and were shot into the world by a violent contraction. "Nature," says Mr. Squeers, "is a rum 'un." Why she made sport of this poor woman I know not, I can only say it was, to her, a unique experience in a prolonged course of maternity, and that all the chief actors in this little drama, the mother, the child, the "howdie" and the doctor, are still alive.

Case 2 occurred at Grenfell in 1868. I was at that time living at Forbes, a distance of 40 miles, and one day in February of that year received a telegram from the late Dr. Beattie, then practising at Grenfell, asking my assistance without delay. I arrived at my destination a little after sundown, and found the patient had been in labour for 48 hours. She was a young married woman of perhaps 28 years of age, first labour; she had been a governess before her marriage, was of delicate constitution, and nervous temperament. The presentation was very similar to the case I have just spoken of, right arm extending, right shoulder tightly wedged into pelvis, head resting on brim, &c. My friend Dr. Beattie had endeavoured to turn, but finding that impossible, had telegraphed for assistance and waited meanwhile. The patient was too exhausted to admit of chloroform; the pains had ceased, and I feared to attempt version until she rallied; I therefore advised the administration of morphia, and a dose of half a grain was given by the mouth. The day of hypodermics had hardly set in then. Tired with a long journey, I lay on a sofa, and was awakened in four or five hours, to find that pains had returned, and labour had recommenced. On examination the shoulder with the extruding arm was found to have receded and the breech occupied their place. Delivery was soon completed, but the shock which the patient had undergone was too much for her feeble constitution, and she sank in 24 hours, from exhaustion.

This case has always been a puzzle to me; the mechanism was doubtless the same as in that of the strong and robust woman, but where was the force? The hand was undoubtedly extruded, or I might have thought there had been a mistake between hand and foot, but both Dr. Beattie, an expert accoucheur, and myself assured ourselves of the correctness of the diagnosis. It would appear as if this process of version in an utterly jaded and relaxed uterus took place by slow degrees during sleep induced by a narcotic, which probably produced a state of hypnotism, but acted as a stimulant of uterine action, and the contractile pains returning, set in as in the former case from left to right and completed the version.

Cases of spontaneous version are rare: we read of one in Genesis which was complicated with a double birth, but I accept the history with hesitation as having been written by a layman.

I relate the foregoing cases because of their rarity. I do not think I have misstated any particulars of circumstances or surroundings of either case. Perhaps the best lesson to be derived from such an experience is that it should strengthen our faith in the resources and potentiality of the "*Vis medicatrix naturæ*."

PROCEEDINGS OF SOCIETIES.

SOUTH AUSTRALIAN BRANCH OF THE BRITISH MEDICAL ASSOCIATION.

MONTHLY Meeting, held in Adelaide on August 28, 1890. Present: Dr. Symons (Vice-president) in the chair, Drs. London, Evans, Verco, Hayward, Michie, Gregerson, T. K. Hamilton, Lermite, and the Hon. Secretary.

The minutes of the previous meeting were read and confirmed. An apology was received from the President, who was unable to attend.

FREDERICK GOLDSMITH, M.B., Ch. B. (Adelaide), and John Michie, M.B., Ch. B. (Melbourne), both residing at the Adelaide Hospital, were elected members of the British Medical Association and its South Australian Branch.

PROFESSOR WATSON showed the following pathological specimens:—

1. Central Sarcoma simulating periostitis, from youth *æt.* 18, who three weeks before death received a severe blow on a painless swelling of lower jaw, first noticed three months previously. Severe constitutional symptoms ensued and patient died with loughing of opposite tonsil, septic infarcts of kidneys, &c.

2. Central Sarcoma of head of tibia from man *æt.* 22, which simulated bone abscess. Its true nature becoming apparent on incision, amputation through thigh was resorted to.

3. Multiple costo-vertebral synostosis co-existing with old united fracture of the immovable ribs.

4. Vertebral synostosis and consequent immobility of dorsal spinal column. Both the above removed from aged dissecting-room subjects.

5. Two specimens of popliteal necrosis of old standing. In both cases amputation through lower third of femur was the final result.

6. Tibia showing exostosis into popliteus muscle with outward deflection of popliteal artery.

7. Large extra dural clot compressing right cerebral hemisphere. A fissured fracture extended from foramen lacerum outwards between squamous and petrous portion of temporal into posterior part of parietal bone, across a branch of post division of middle meningeal artery. From a man *æt.* 40, who was stunned for five minutes by a fall from his horse; on regaining consciousness he walked a quarter of a mile to a roadside inn, and finally becoming unconscious six hours later; he died in coma 14 hours after receipt of injury.

8. Bony thorax of boy, *æt.* 15, with caries of bodies of several dorsal vertebrae and corresponding angular curvature. The aorta is adherent to a fibrous layer, representing the anterior common ligament, between which and the eroded bodies is a large collection of soft gritty puriform material. Patient died of basilar meningitis.

9. Generally enlarged heart, with *ante-mortem* parietal clots, from a dropsical male, *æt.* 45, who had an attack of acute nephritis two years before death. Kidneys were granular; spleen and liver congested, enlarged, and very firm.

10. Uterus from woman *æt.* 50, presenting two myomata, one subserous, the other submucous, both becoming pedunculated.

DR. VERCO showed a girl whose cheek, destroyed by cancerum oris, he had restored by transplantation of a skin flap from the arm.

DR. FOULTON showed a man on whom he had performed nephrotomy for suspected calculus, and whose symptoms had been relieved, though no stone was found.

THE HON. SECRETARY read, for Dr. J. A. G. Hamilton (President), in his absence, a paper on "The Radical cure of Hernia," with illustrative cases.

DR. FOULTON read a paper on the same subject. A short discussion followed.

RADICAL CURE OF HERNIA.

By J. A. G. HAMILTON, M.B., &c.

IN reading a paper on the above subject I have no intention of reviewing the many operations at present in use. Whatever method might be adopted, I think most surgeons are agreed upon the method of closing in some way the mouth of the canal. With strict antiseptic precautions the operation might be almost said to be devoid of danger. I think the radical cure of hernia might be extended beyond the limits generally laid down for its use.

It has been urged that it should only be done in cases which cannot be controlled by a truss, or where the wearing of a truss is productive of distress; but I think we might go further than that and say that the inconvenience of wearing a truss, and the restraint upon the exercises of the young, besides the disqualification a hernia is to many kinds of employment, enormously outweigh the slight risk of such an operation. We frequently meet with men, especially old men, who cannot or will not wear a truss. These men go about in constant danger, and I think we put them in a better position by curing or attempting to cure their rupture. And in the case of a very large and old standing genital hernia, if the operation is not a perfect success it will probably be a partial one, and the recurring hernia is commonly much more amenable to a truss. In my hospital experience in the colony it has often struck me what a number of those men known as "swagmen" are ruptured, and how few of them wear a truss, or if they do wear one it is generally an old broken or badly-fitting one, doing more harm than good. Those men living in the bush, often far away from medical assistance, live in daily danger of strangulation, are I think proper cases for operation, even at an advanced age; and some of that class known as "hospital birds" use their hernia as a not very creditable means of existence, going from one hospital to another, and if you can get them to consent to an operation you at any rate take away their excuse for idleness.

Unfortunately, from a statistical point of view, these are not a very satisfactory class of case, as you rarely see or hear of them after they leave the hospital. Several of the cases I quote below are of this class, so I am unable to speak for the permanency of the operation. As regards the various operations I have only had experience of

"Wood's," "Bank's" (or a modification of his) and "Ball's." My first two cases, operated on some years ago, were done by Wood's method, and although in one case the result was good, I do not think it is an operation which commends itself to the surgeon of the present day. You have to conduct it subcutaneously, working more or less in the dark, and on account of the presence of the large pad over which the wires are fastened it is almost impossible to keep the wound aseptic. My next few cases I did by Bank's method, dissecting the sac up, ligaturing it as high up as possible, and cutting it off, and finally bringing the pillars of the ring together by wire sutures, leaving them in position. Some believe that the wire remains in position and does not work its way out, and that it maintains by its presence the permanent apposition of the parts. I admit that I fell into the then popular fallacy that wire left in position had this effect, and on the first flush this idea looked a very feasible one. No doubt silver or gold wire when properly applied, without leaving any sharp points projecting, may remain in the tissues for an indefinite time without setting up an irritation; but granting that, does the mere fact of its doing so serve any purpose? I think not. It serves a purpose as long as it exerts traction on the pillars, but it will by its traction ulcerate through the tissues until it reaches a point of rest; after that it is no longer an active agent, but becomes a foreign body, which occasionally gives rise to disturbance, and if the hernia should recover, it may be a positive source of danger by ulcerating through or constricting a fold of bowel. Sutures are only required to excite such irritation as will cause abundant cut-pouring of lymph, and to close the canal while cicatricial tissue is being consolidated. Silk catgut or kangaroo tendon will produce this effect, and will resist the action of the tissues quite long enough to secure firm adhesion, provided the material is sufficiently stout to prevent its rapidly ulcerating through the tissues. I think catgut and kangaroo tendon are preferable to silk. No doubt when a large piece of omentum has to be ligatured and cut off, it is safer to use silk; but in using it to secure the pad of peritoneums it sometimes acts as a foreign body, forms an abscess, and eventually sloughs its way out through an opening in the wound. Ball's operation is the one I have used in my more recent cases, and I think I may safely say it is now looked upon as the most satisfactory operation for the radical cure of hernia. In this operation the sac is dissected up, twisted, a catgut ligature is passed round the neck, and stout catgut or silk ligatures are passed through the pillars of the ring and through the twisted stump

to prevent untwisting. This presents a capital plug to the ring, and the danger of septic peritonitis is almost nil, as the peritoneum in the bulk of cases is practically not opened, as the ligature round the sac is applied before it is divided. If the sac is of a great size, as much of the distal portions of it as may be advisable can be removed. Another advantage is that the peritoneum forming the inguinal pouch for some distance up is involved in the general torsion, and thereby helps to prevent a recurrence of the hernia.

In one or two of my cases I had intended doing Ball's operation, but finding a considerable amount of adherent omentum, and rather than run the risk of hæmorrhage by dissecting it off, I put a stout ligature round sac and omentum together, cut off the redendort portion, and fixed the stump to the pillars of the ring without twisting it.

I will now give a few notes of 16 cases operated on by me by various methods.

Case 1.—J.L., aged 62, farmer. He presented a very large scrotal hernia of about 20 years' standing. It was reducible, but came down again at once; trusses had failed to keep it up, and he was very anxious to have something done for it. Operation, June 9, 1885, by Wood's method. A rather smart swelling in his scrotum and testicles followed; some pus formed. The wound slowly granulated, but in a month's time it was quite healed; he wore a light truss for a couple of months after operation. I have seen this man frequently since, and he has never had any return of the hernia.

Case 2.—Mrs. W., aged 40, washerwoman. A very large femoral hernia; wears a truss, but when she does any heavy work it comes down; unable to earn her living as a washerwoman. Some 12 months before, the hernia became strangulated, but I was able to reduce it by taxis, under chloroform; very anxious to have it cured. Wood's operation performed November 6, 1886. Considerable inflammation and thickening followed, and the wound did not heal kindly. The hernia returned again in a few months' time, but she is now able to restrain it by a properly fitting truss.

Case 3.—Mrs. S., aged 78. Strangulated femoral hernia of five days' standing and stercoraceous vomiting, and great collapse. Operation, August 26, 1886. Sac opened, and bowel returned with the sac. The pillars of the ring were brought together with silk sutures. This woman died about six months afterwards from general debility. There had been no return of the hernia.

Case 4.—W.B., aged 10 years. A congenital inguinal hernia of right side. Operation, December 19, 1887. The sac was dissected up, and was with considerable difficulty separated from the cord. The sac was then divided, the distal end was sutured with catgut, and the proximal end was stitched to the pillars of the ring with silk sutures. The wound healed by first intention, and I heard from his father, 12 months after operation, that the boy had no sign of return of hernia.

Case 5.—Wm. B., aged 38, bushman; small inguinal hernia; reducible; had never worn a truss; anxious to have something done, as he could not follow his usual employment of horsebreaking. Operation, November 15, 1888. The sac was dissected up with great difficulty, as the cord and vessels were closely adherent to it. It was then ligatured as high up as possible and removed; the pillars of the ring were brought together with four wire sutures. The operation was followed by considerable thickening and pain down the cord and into the testicle. This did not disappear for nearly two months; left the hospital 15 weeks after operation; has not been heard of since.

Case 6.—J. W., aged 38, swagman; large inguinal hernia; reducible; has never worn a truss. Operation, November 24, 1888. Same as preceding case, only sac easier dissected out; wound healed rapidly; no swelling; left hospital five weeks after operation; has not been seen since or heard of.

Case 7.—A. S., aged 23, bank clerk; a small inguinal hernia of about two years' standing; reducible; has always worn a truss, but complains bitterly of the inconvenience and distress of it; is afraid to engage in any active exercise; wished to have it cured, if possible. Operation, September 23, 1888. Varicocele on same side as hernia; sac dissected up, and with considerable difficulty separated from the cord and varicose veins. Sac ligatured, cut off, and stitched to pillars of ring with silk sutures; pillars of canal stitched together with same material; varicose veins ligatured with two catgut sutures, and about an inch of the intervening portion cut off; wound brought together with deep and superficial catgut sutures; a small drain tube put in. The next day, and for some time, the scrotum was enormously swollen and painful. This remained for some time, and a small abscess formed at upper part of scrotum. The wound healed slowly, the swelling gradually went down, and in six weeks he was able to resume his employment, wearing a light truss. I have seen him frequently since operation; he is now able to enjoy all active exercises, cricket, tennis, &c.; no return of hernia. The varicocele is also cured. No doubt in this case

the subsequent inflammation and swelling of scrotum and testicle was caused by operating on the varicose veins at the same time as doing the radical operation for the hernia.

Case 9.—Mrs. B., aged 52, has had a large femoral hernia for about 20 years; never used a truss till about three years ago, when the hernia became strangulated. I succeeded in returning it by taxis, and advised her to wear a truss; this she did, but suffered a good deal of inconvenience from it; she sometimes left it off. On the evening of November 28, 1888, having left off her truss, the hernia suddenly became strangulated. I saw her about 10 p.m., half an hour after the first symptoms of pain, and found her suffering from a large strangulated femoral hernia. Taxis was tried under chloroform, but without effect; I advised an operation but she would not hear of it, so put her on opium. The next morning things were in the same state, suffering great pain. After a deal of persuasion she consented to have an operation performed. This was commenced at 3 p.m. on the 29th, 17 hours after strangulation. Operated in the usual way. The sac was found to contain a piece of purple-coloured omentum about the size of a closed fist, and a small knuckle of deeply-congested, claret-coloured intestine, still retaining to some extent its glistening appearance; hot sponges wrung out of antiseptic lotion were applied to the strangulated gut for some time, and it was considered safe to return it; the pieces of omentum could not be returned, so it was ligatured in sections and cut off, the sac was dissected up, ligatured, and cut off high up; the stump of omentum with the ligatured sac were fixed to the pillars of the ring and the wound brought together with buried and superficial catgut sutures. The next day she was free from pain but collapsed, smart and intermittent pulse, hiccup, and delirium; she died the same night, evidently from gangrene of the strangulated gut. I give the notes of this case in full, as I think it is somewhat unusual to find gangrene of the bowel after only 15 hours constriction.

Case 10.—W. A., aged 63.—A very large scrotal hernia of many years standing; all forms of truss had failed to keep it up and he was quite incapacitated from work. Operation, June 1, 1889. On dissecting up sac a large piece of omentum was found adherent to it; both were ligatured together, cut off, and stitched to pillars of ring by two stout silk ligatures. The lower portion of wound healed by first intention but the upper portion remained open, eventually one of the silk ligatures came out through the opening and the wound healed; he was discharged on August 16. When last I heard of him he had no return of the hernia.

Case 11.—P. W., aged 70, farmer.—Twelve months before noticed small lump in right groin; no inconvenience from it; wore no truss. On June 13, 1889, slipped from a ladder; found pain in groin which increased, commenced vomiting next morning.

State on admission, June 17, four days after strangulation. Very much collapsed; vomiting constantly; great pain all over abdomen; small tender tumour felt in right groin, very hard. Taxis was tried without avail, so the usual operation was performed to relieve the strangulation. On opening the sac a small knuckle of intestine surrounded by omentum was found, both highly congested, but the gut was glistening. Ring was divided and intestine slipped back, but the omentum was found adherent to the sac and both were ligatured with catgut, divided, and fixed to pillars of ring with stout catgut; the canal was closed with three catgut sutures, the deep and superficial tissues were brought together with continuous catgut sutures; no drain tube used. Dressings opened for first time on ninth day, when primary union was found all along wound. Allowed up on 25th day and discharged at end of fifth week. I see him frequently, and now, 14 months after operation, no return of hernia.

Case 12.—S. A. McK., aged 40, married, seven children, three months pregnant, has had a rupture for eight years; never wore a truss; hernia small at first; used to go back at night; has not done so lately; gradually getting larger and more painful.

July 9, 1889, on going to stoop suddenly seized with pains over hernia and over lower part of abdomen. On examination two hours afterwards a tumour about size of an orange was found in right femoral region; taxis under chloroform was tried without avail. Operated in usual way; sac found to contain good deal of clear fluid; a large piece of healthy looking omentum, and a large knuckle of intestine of a deep purple color; ring divided, intestine and omentum returned; a small adherent piece of omentum was ligatured and cut off; sac carefully dissected up; ligatured with catgut; twisted and fixed to pillars of ring with catgut sutures; canal closed in same way; wound brought together with deep and superficial catgut sutures; no drain tube used; wound healed well. Discharged at end of fourth week. No return of hernia at time of confinement, February 5, 1890; but she had a very protracted and severe labour, requiring forceps, and the hernia returned after she got along again.

Case 13.—E. F., aged 26, farmer; inguinal hernia; reducible; of about two years' standing; wore no truss; anxious to have it cured.

Operation, July 29, 1889. On putting him

under chloroform the canal was found empty, so pillars of ring and canal were brought together with catgut sutures; the wound treated as in the former cases; no drain tube used; dressed for first time on 10th day; primary union all along line of sutures; no swelling; allowed to go home on 30th day. Up to the present, now 12 months after operation, there is no return of hernia.

Case 14.—F. N., aged four months, male, large double congenital hernia; various forms of truss were tried without effect.

Operation, August 22, 1889. One side done at a time. The sac was isolated with difficulty from the cord, to which structure it was closely adherent; it was thus divided and dealt with as the sac of an acquired hernia; the proximal end was fixed to ring, and the distal end stitched with catgut; the canal was closed with catgut sutures; the wound healed well, although the dressings were constantly wet with urine, despite an oil-silk covering and a double spica bandage. In a month's time the second side was operated on in the same manner as the first; unfortunately the sac was divided before it was ligatured; the child suddenly vomited, and a large quantity of intestine slipped down; great difficulty was found in returning this, although the ring was enlarged to give more room, consequently the bowel was subjected to a good deal of handling and some bruising. The next day the temperature was 103; great pain all over abdomen; child died on third day from peritonitis, no doubt caused by the amount of handling the intestine had to receive in trying to return it through the very small ring.

Case 15.—J. H., swagman, aged 57; very large scrotal hernia of left side; irreducible; has never worn a truss. Operation, October 13, 1889. Sac twisted same as in preceding operations; wound healed well; discharged six weeks after operation; has not since been heard of.

Case 16.—J. T., aged 67, no occupation; very large scrotal hernia of many years' standing; has never worn a truss. Operation, March 27, 1890. Great difficulty in dissecting out sac, as it was closely adherent to tissues all round; it was eventually cleared, twisted, and ligatured to pillars of ring; wound treated as in other cases, but a small drain tube left in, as the tissues had been a good deal torn and pulled about. Dressed on fourth day; considerable pain and swelling down cord and with testicle; this did not disappear till end of fourth week; upper angle of wound remained open; a large piece of sloughing sac was drawn out through opening in wound. After this it healed quickly; discharged at end of sixth week; no return of hernia when last heard of, four months after operation.

Just a word about the closing of the wound. I think it of great importance, not only in this but in all wounds such as excision of breast, removal of tumours, &c., where a cavity is left, to thoroughly approximate all the deep portions of the wound up to the skin with an interrupted catgut suture. This brings the parts closely together, and does not allow any room for collection of fluid of any sort, and does away with the necessity of a drainage tube.

I will not attempt any statistics of the results of these operations, as many of the cases were lost sight of after the operation, and nothing is known as to the permanency of the operation; but I think I might fairly claim to have added force to my original contention that the radical operation for hernia is a safe and justifiable one, and one that might be performed in most cases where the hernia is any source of inconvenience or trouble to the sufferer.

ON RADICAL OPERATIONS FOR HERNIA.

By B. POULTON, M.D., CH.B., M.R.C.S.,
HON. SURGEON ADELAIDE HOSPITAL.

My contribution to the study of the radical cure of hernia is but scanty, as the number of cases noted and on which I have operated is very small; nor has sufficient time elapsed since the operations to speak with assurance as to their ultimate results.

Only very occasionally does a person suffering from hernia apply to me for operative relief on account of the irksomeness or inefficiency of a truss, nor do I deem it desirable to recommend operative measures for the cure of a hernia which may be easily and securely retained by a comfortable apparatus. Whether with the knowledge of the frequency with which operation is resorted to in England for the replacement and retention of reducible herniæ we shall here resort more often to the knife I do not know, certainly in the past little has been done.

The records of the Adelaide Hospital for the last 10 years show that 33 operations only have been performed there for hernia, and about half these were for strangulation without reference to radical cure.

I am disposed to think that there are a good many men suffering from the difficulties and dangers inseparable from the wearing of badly-made and ill-fitting trusses whose lives would be rendered safer and their capacity for labour increased by the performance of an operation for the obliteration of the sac and a narrowing of the inguinal canal and its orifices.

Any such operation should not be considered thoroughly satisfactory unless followed by permanent cure of the hernia, without the accessory aid of a truss; though the condition of a man, as regards working power, comfort, and safety, after an operation, though requiring a truss, will be much better than where he depends entirely for the absolute retention of the constantly descending gut on a truss alone.

I shall confine my remarks to operations in inguinal hernia, and to various modifications of the open method which presents many manifest advantages over any subcutaneous suturing of unseen tissues.

The insertion of sutures without incision, as by Mr. Fitzgerald's method, precludes of course any examination of the sac or its contents, and does not allow of eradication of the sac.

To cut down upon the structures involved affords of course opportunity for careful examination of the hernial contents, removal of adherent omentum or an useless testicle, and is not a dangerous proceeding, for the peritoneal cavity is completely closed by suture of the sac.

One sufficiently serious complication which one of the cases I bring before you illustrates, is the sloughing of the testis from interference with the cord in separating it from the sac, and this case further emphasizes the safety from peritonitis afforded by ligature of the sac. I have been much disappointed with the ulceration attending the separation of silk sutures, and in my small experience find strong kangaroo tendons more satisfactory. Wire sutures I have not used, as I cannot understand how a few slender metallic bars can be expected to act as a permanent and effectual barrier: so long as they are tense they must tend to ulcerate through and weaken the rings, when they are lax their restraining influence can be but slight.

The sutures used close the sac, fix its closed end inside the internal ring, or at the internal ring, approximate the sides of the canal and both rings, and cause adhesive inflammation. Having temporarily prevented descent of the hernia and kept the parts in apposition until adhesions have formed, their presence is not required. Silk generally sets up suppurative inflammation, and has to be removed; catgut lasts hardly long enough; wallaby tendon, thicker and more enduring than catgut, does not dissolve for from 10 to 14 days. It requires to be tied very carefully and firmly to prevent slipping. I think a hardened and less absorbable kangaroo tendon would supply the beau ideal suture.

The dissection and separation of the whole of the sac in McEwen's operation appears to me unnecessary, as it lengthens its duration and may

damage the cord. Where the structures of the cord are spread over the sac I should prefer to separate them only sufficiently to divide it, leaving the distal end.

I have operated in all on six cases, and will, with your permission, read extracts from the notes for which I am much indebted to my house surgeons, Drs. Lynch and Michie.

In Case 6, operated on three weeks ago, I adopted the high transverse incision suggested by Dr. Kingscote, of Salisbury, in a recent number of the *British Medical Journal*. This incision is further away from the pubis and groin than the usual incision, less liable to infection, and its cicatrix, being above the inner ring, is not a subsequent source of weakness.

NOTES OF CASES OF HERNIA.

1. W. C., æt 54, ironmoulder. Hernia came on after straining himself whilst working four years previously. Wears a truss which fits badly. Lately the hernia has increased in size. Patient desires an operation.

February 6th.—Patient under ether. Dr. Poulton performed an operation for radical cure of hernia after Barker's method. The sac was divided between two ligatures, and the upper part stitched into the abdominal wall at the sides of the internal ring. The pillars were brought together with tendon sutures.

February 9th.—Wound healthy. Testicle and cord greatly swollen; gas inside at the top of the testicle; patient has cough with viscid expectoration.

February 11th.—Discharge of pus from upper part of wound; scrotum is enlarged, tapped with fine trocar; several drachms of fluid removed.

February 16th.—A considerable amount of purulent discharge continues; some bagging of pus in the scrotum; an opening made in the lower part of the scrotum.

February 20th.—Under ether, the canal of the sac was opened; sloughing tissue removed.

March 6th.—Under ether, the right testicle was removed through the original wound, the cord was ligatured with silks, no sutures inserted; subsequently there was very little discharge, and patient gradually improved. The ends of the ligature came away on April 8th, 33 days after; discharged April 9th. His wife reports him quite well and hard at work.

2. F. P., æt 18, boundary rider, admitted May 29th, 1889. Patient has always noticed his right testicle was smaller and not so low down as the left. Eighteen months previously he struck himself heavily on the pommel of a saddle, after which he noticed a swelling in the right groin.

On examination the right testicle is found to be high up in the inguinal canal, it is small, but testicular sensation is present.

After standing, or coughing, or straining, a hernia comes down which nearly reaches the scrotum.

June 8th.—Under ether the testicle was removed and the inguinal ring closed by sutures; next day had pain in abdomen.

June 15th.—Silver stitches removed and wound dressed.

June 20th.—The tendon drainage sutures were removed; wound healed.

S. J. S. B., æt 62, agent, admitted 1st April, 1890. Patient stated that he became ruptured on right side three months ago, it was then about the size of a small orange, this was reduced; he then wore a truss which kept it up, until a week before admission, when it came down again. An attempt was made to reduce it but without success. He has dragging pain in it when walking about, and any attempt to reduce it causes a feeling of nausea.

He has had a rupture of the left side for 16 years, this is kept up with a truss.

On examination there is found to be an oval shaped tumour about the size of a pigeon's egg in the right inguinal region situated over the external abdominal ring, its long axis parallel to just above Poupart's ligament. The tumour feels hard and tense, freely moveable, no fluctuation. Distinct cough impulse, but straining does not cause the tumour to descend into the scrotum; spermatic cord can be felt; no thickening of cord; pressure on the tumour causes pain; both testicles are in the scrotum; the external abdominal ring is distinctly enlarged.

April 10.—Patient anesthetized with ether. Dr. Poulton made a transverse incision over the tumour, parallel to Poupart's ligament, about four inches in length. The tissues down to the tumour were dissected through, and the tumour found to be an epiplocele. The portion of omentum forming the tumour was partially separated from the rest of the omentum by a constriction in the neck of the sac. A ligature was passed round the neck of the tumour, and the part below it removed. No drainage tube left in; wound sutured with tendon; dressed with iodoform and carbolic gauze.

April 11.—Wound dressed and drainage tube inserted.

April 12.—Some overlapping of the edges of the wound, sutures removed, and others inserted more superficially; drainage tube removed. Subsequently, healing went on without interruption, and patient was discharged on the 3rd May.

Reports himself this month as quite well ; is going about actively and not wearing a truss.

4. John W., *set.* 20, engine-driver, admitted June 24. Complains of double rupture. He states that it came down on the left side eight weeks ago, while coughing. It was then about the size of a hen's egg ; it could be easily reduced.

At times he has a similar swelling on the right side, which causes him considerable pain. He now states that he is unable to work on account of the pain and inability to wear a truss over it. He says he will not attempt any more trusses.

June 28.—Patient under ether. Dr. Poulton made a longitudinal incision over the external abdominal ring, the hernia being previously reduced. The pillars of the ring were approximated by silk sutures ; the sac of the hernia left untouched. A similar operation on the other side ; drain tubes inserted, and wound approximated with tendon and horsehair sutures.

July 3.—Temperature rose to 101.8° in the evening ; wound looking healthy ; has some pain on micturition ; passes water more frequently.

July 5.—A small quantity of pus was pressed out of the upper part of the wound ; small drain tubes inserted.

July 9.—Temperature does not rise above 99.6° ; still slight discharge.

July 16.—Owing to discharge continuing the wound was opened up, and a slough found in the right one. A few days later, the old suture came away from the right side, that from the left side a few days afterwards ; wound then healed up.

Reported to-day, August 28, as having no trouble with his rupture, which has not come down ; wears no truss.

5. F. K., four months ; admitted September 18, 1888 ; strangulated hernia ; radical operation. The child's mother stated that he has had a rupture since birth, but that it has increased in size and would not return since last night. He was retching all night ; has had no passage of *fæces* or *flatus* since the swelling increased.

Child was anesthetized. Dr. Poulton cut down on it. The gut was found to be a good deal congested, but shiny ; the constriction was divided, and the sac stitched with silk, and the pillars of the ring brought together with silk sutures.

September 19.—Child was restless all night ; wound looks well.

September 20.—Bowels open once yesterday.

Discharged on the 20th. The silk ligatures had subsequently to be removed on account of their causing suppuration. The case did well, and the hernia had not returned when the child died of croup in 1889.

6. July 5, 1890.—A. G., *set.* 29, bushman. Patient was admitted on July 5, 1890, complaining of a discharging sore on his right cheek which gave some trouble in treating. After this healed patient stated that he had a hernia—had it for some years ; wore a truss, but recently had not been able to keep it on, and had a good deal of pain.

On examination there is a left inguinal hernia, which can be reduced by taxis. Patient wishes to have it operated on.

August 4, 1890.—Patient was given ether. A transverse incision was made about an inch above the pubes and extending slightly downwards and outwards over the prominent part of the hernia ; length of incision about three inches. The structures were dissected through down to the sac, which was opened. The hernia was found to be purely omental and congenital, the testicle, which was atrophied, occupying the lower part of the sac. The lower part of the omentum was ligatured with silk and cut off, the stump returned into the abdomen. The sac was divided transversely to the part containing the cord ; the upper portion secured with tendon sutures and returned within the abdomen ; the lower portion brought together with a few sutures, and the pillars of the ring approximated with tendon. Edges of wound brought together with tendon and horsehair, and a drain tube inserted.

August 9, 1890.—Drain tube removed ; very little discharge ; temperature normal, slightly varying (97°-100°) all through.

August 11, 1890.—Stitches removed ; bowels opened yesterday and enema ; slight pain in abdomen.

August 18, 1890.—Wound healed ; patient allowed up on 23rd with spica bandage and pad.

DR. HAYWARD and Lendon spoke of the frequency with which hernia disappeared in early childhood, and of its association with phimosis. Dr. Lendon related a case in which careful use of a truss was followed by the cure of a hernia in an adult.

DR. VERCO would have been glad to have heard statistics as to the fatality of operations for the radical cure of hernia ; such information would guide one in advising patients.

DR. LERMITTE would never think of operating on young children.

DR. POULTON regretted the absence of Dr. J. A. G. Hamilton. He quite agreed that operations in the hernia of children were uncalled for. As regarded fatality, there had been no fatal cases in the Adelaide Hospital ; and in recommending the operation he had been guided by the experience of good men throughout the United Kingdom. He felt justified in recommending operation to a hard working man, who was impeded in his work by a truss or who found difficulty in retaining his hernia by means of an apparatus.

The following paper was read at the preceding meeting:—

ERYTHEMA NODOSUM—AN ACUTE SPECIFIC FEVER.

BY ALFRED AUSTIN LONDON, M.D. (LOND.),
LECTURER ON FORENSIC MEDICINE IN THE
UNIVERSITY OF ADELAIDE, HONORARY
ASSISTANT PHYSICIAN, ADELAIDE HOSPITAL,
&c.

For some time past I have been of opinion that Erythema Nodosum is not merely a skin disease; others have entertained the same idea, but, so far as I am aware, no one has ventured yet to express an opinion as to what the real nature of the disease may be. The object of this preliminary communication is to narrate the circumstances which have influenced me in deciding in my own mind that erythema nodosum is in reality an acute specific fever, in the hope that I may thereby initiate a profitable and interesting discussion.

While of course it cannot be expected that my views will be accepted in their entirety, still if only I am successful in directing your attention to some clinical features of this affection, which in all probability you will have future opportunities for verifying or disproving, I shall feel justified in having brought this subject under your notice. At the outset I may disclaim any intention of giving you a regular and systematic description of the disease, as I desire to confine my remarks to such points as bear upon the actual nature of it, and the disputed question of its association with other diseases.

My attention was originally directed to the study of erythema nodosum by the circumstance of its occurring in a very severe form in a near relative, a lad of about 16 years of age, whom I had under observation and treatment whilst I was staying in the house in November, 1879. The temperature chart which was kept at the time has been mislaid, but I recollect that the temperature on more than one occasion reached about 105° F. in the mouth; that rigors occurred; that the pulse was markedly dicrotic; that the tongue was furred and dry; the bowels obstinately constipated; the urine concentrated and loaded with lithates; in short, that for about ten days he had a febrile attack which gave me considerable anxiety. I have a vivid recollection, too, of the extent and severity of the accompanying skin affection, for there were patches of erythema nodosum not only in the typical situations on the extensor aspects of the limbs but also over the whole trunk and face; and when the patches declined into the bruise-like stage the

patient presented a most extraordinary aspect, almost as though he had been "thrashed within an inch of his life," for without exaggeration I think that I may say that there was scarcely an area of skin of the size of the palm of one's hand free from this appearance of bruising. I had never seen such a severe case before, nor have I seen any case that has approached it in severity since. The patient was otherwise perfectly healthy, free from rheumatic taint, and he did not present either at the time or afterwards any evidence of cardiac or arthritic complication. He remained weak for some time, but eventually completely regained his strength.

This case naturally made a profound impression upon my mind, for my previous experience of erythema nodosum had been limited to a few cases seen in hospital practice, in which the skin phenomena were but slight and the pyrexial disturbance was insignificant, and the prevailing doctrine was that it was a skin affection frequently, if not always, associated with and dependent upon a rheumatic diathesis. It was not till I settled in practice in Adelaide in 1884 that I again had opportunities for studying this complaint; but since then I have noted several points which justify me, as I think, in my estimate of the proper position for erythema nodosum in the nomenclature of diseases.

The first point which struck me was this, that when I saw one case I was likely to come across more in a short space of time; but I have not sufficient observations of my own to show that it is more prevalent at one time of the year than another, or that any particular kind of weather predisposes to it.

The second point I noticed was, that it seemed to have a preference for certain suburban localities, Kent Town being especially associated with erythema nodosum, in my experience, and the city of Adelaide proper being especially free from it.

In 1886 a circumstance occurred, the import of which I did not then fully appreciate. I was attending, in conjunction with Dr. Davies Thomas, a lady about 45 years of age, who was suffering from an attack of erythema nodosum accompanied by considerable fever and marked prostration, and who was confined to an upstairs room, at the same time that her son, aged 19 years, was laid up with a suppurating bubo in a room on the ground floor. During the convalescence of the mother the son developed the same disease. This was interpreted as merely a coincidence; it was not suspected that the disease might be communicable, but it was thought that the same cause—whatever that cause might be—had given rise to it in the mother and subsequently in the son.

In 1887 another link was added to the chain of observations. Up to this time I had supposed that the pyrexia was the result of the local inflammation of the skin, and probably directly proportional to it in severity, but whilst in attendance for several days on a little girl, four years old, who had a mild febrile attack, which from the fact of her residence in a suburb where typhoid was then prevalent, I had too confidently assured the parents was enteric fever in the early stage, I was surprised one day to find patches of erythema nodosum on the legs instead of the roseola of enteric fever. This pyrexia must have existed for at least a week before the spots developed. This is not an isolated observation, for only last month, when the influenza epidemic was on the wane, I met with a case of erythema nodosum in an adult woman, who described headaches, shivers, and general feverishness as having preceded the appearance of the spots by exactly *nine* days, and thought that, as others had recently had influenza in the same house with somewhat similar symptoms, therefore she must be suffering from the prevailing disease. In this case there also appeared to be a distinct exacerbation in the premonitory symptoms on the *third* day before the rash appeared. In a third instance, which occurred in November, 1888, my notes remind me that the symptoms of the prodromal stages lasted exactly *ten* days, and here again there was a marked increase in their severity on the *fourth* day before the nodes came out. This would appear to indicate that the prodromal stage comprises a period of incubation and a period of invasion, and although I do not wish to attempt to prove too much, I may mention that I am now attending a young lady who was taken ill on July 4th, who became much worse and sent for me on July 11th, the rash appearing on the morning of the 14th.

As regards the character of the symptoms which appear during this prodromal stage, there is but little difference to be noticed from those which accompany any illness in which the bodily temperature is raised; hence they are supposed to be premonitory of typhoid fever or of influenza, as in the foregoing cases, or else to be the result of a sunstroke contracted six months previously, or to be symptomatic of inflammation of the lungs, as in two other instances I can recall. The majority of patients are satisfied, however, to lay the flattering unction to their souls that they have "taken cold." I do not therefore propose to enumerate the prodromal symptoms of erythema nodosum, but I must allude to one, which is not strictly prodromal, since it appears both before and after the rash comes out, for drawing attention to which we are indebted to Dr. Bickle, of

Mount Barker—I mean conjunctival phlyctenulæ, which I have met with in two recent cases.

With the stage of eruption we are all so familiar that I will not say more than this, that its behaviour is quite consistent with the theory of its being the rash of an acute specific disease. It seems to take a fairly definite time to reach its full development, perhaps about 48 hours from the appearance of the first characteristic spots, to then remain stationary for about two or three days, when the earliest spots begin to fade, and during this time the fever remains high. When the patches begin to look like bruises the fever abates, but there is no crisis. This brief description may require modification, for example in some cases relapses seem to occur and fresh spots to appear. Finally, there is a stage of debility and a rather slow convalescence.

I have already alluded to an instance of two patients suffering from erythema nodosum in the same house within a short time of one another; in February, 1890, this experience was repeated. A girl, aged 18 years, had been staying away from her home about a week before she saw the rash, and on the third or fourth day after its appearance was brought to me (Feb. 11); she then stayed at her own home till the 15th, and on the 16th her brother, aged 9 years, developed typical nodes. I mention these cases for what they are worth; they do not convince me that erythema nodosum is infectious, but they indicate the possibility that such may be the case.

Hitherto I have spoken of erythema nodosum because it is an easily recognized exanthema: but the typical nodose appearance of the eruption is sometimes confined to the lower limbs and always best seen there; elsewhere it presents other appearances, the individual spots being papular, acuminate, acneform or pustular, and by themselves not easily recognized as erythema: this, of course, was pointed out by Hebra when describing erythema multiforme; it seems probable also that the phlyctenule is a similar lesion modified by its occurrence on a mucous membrane.

If my views be correct, it will be hardly necessary to discuss the relationship of the supposed skin disease to the rheumatic diathesis, and certainly my own experience does not corroborate the statement as to their frequent association: it is possible that the prodromal symptoms have been misinterpreted as rheumatic, in default of any other explanation, and the subsequent appearance of the nodes has been supposed to confirm this.

The conclusions at which I have arrived may perhaps best be formulated in a series of propositions for convenience of discussion. They are naturally somewhat provisional and I may have some day to modify them.

1. Erythema nodosum is the skin eruption which characterizes a well-defined acute specific fever.

2. Prior to the eruption, symptoms are met with which vary in severity and which may last as long as ten days. In some instances the prodromata are mild and are overlooked; in others they attract attention and give rise to various mistakes in diagnosis.

3. The stage of eruption lasts a fairly definite time and is accompanied by continued pyrexia: each individual patch runs through a definite course, and relapses occur at times.

4. The stage of decline is gradual, not critical; and is followed by marked debility and convalescence.

5. The relationship to rheumatism is "not proven."

6. Erythema nodosum is but one form of erythema multiforme.

7. Cases occur under such circumstances as to lead us to suspect that the disease is communicable from one person to another.

THE NORTH QUEENSLAND MEDICAL SOCIETY.

THE Quarterly Meeting of the North Queensland Medical Society was held at Charters Towers on Thursday, 10th July, 1890, the President being unavoidably absent, Dr. Graham Brown took the chair.

Two cases were brought under the notice of the Society by Dr. Forbes:—(1) Injury to knee-joint. Piece of granite struck the parts above patella, completely severing all the soft parts down to the bone and opening synovial sac. The divided structures carefully sutured, catgut being used for the deeper parts. Dry boracic dressing applied over all. About again in four weeks with perfect use of joint. A complete cure. (2) Case of old-standing gonorrhoea, set. 50. When it came under observation there was a tumour behind scrotum, and perineal sinus; pain on passing water and stricture. External urethrotomy performed; No. 12 can now be passed, sinus is healed, tumour disappearing, stream of urine as good as ever. All this within a month of operating.

Dr. Graham Browne, the Vice-President, now read his paper on—

CHARTERS TOWERS FROM 1882 TO 1890.

BY DR. GRAHAM BROWNE, B.A., M.D., M. Ch., Hon.-Cons. Medical Officer, Charters Towers District Hospital.

ON behalf of the members of the medical profession practising at Charters Towers and belonging to the N.Q.M.S., I beg to give the warmest welcome to such medical brethren as are visitors on their attendance at the initial meeting of the Society at the premier goldfield of North Queensland. On this occasion I have selected as the subject for a paper, "Charters Towers from 1882 to 1890 from a medical point of view,"

taking up such points of interest to the profession as attracted my attention at different times during this period, and that I thought likely to provoke discussion amongst, or give rise to remarks from, the members of the Society present to-night.

The Charters Towers district was first opened up in 1872 by a large rush of alluvial miners to Milchester, three miles from Charters Towers proper. Somewhat later in the same year, Messrs. Mosman and Charters, while camping at the "Gap," found gold in the creek that runs down from Charters Towers hill in front of what is now known as Dan Hayes' hotel, and on prospecting discovered a reef with payable gold. This was the original North Australian P. C.; it gave the first start to what is now the premier goldfield of North Queensland; and from one of its discoverers, who became the first warden on the field, together with the peculiar character of its hills, Charters Towers takes its name. Rapidly new lines of reef were opened up, the Washington, the Queen, and St. Patrick, and in 1873 Charters Towers became the main centre of the district; the banks and *Northern Miner* office were shifted from Milchester to it, and a temporary hospital erected behind the lower end of Mosman-street. Later, in 1875, Horace Stubbley made his pile in the St. Patrick Block G. M., and in 1878 the permanency of the field was ensured by the Day Dawn P. C. finding their celebrated reef. The field passed through the usual routine of tents, followed by bark humpies; these, in their turn, giving way to substantial weather-board houses, especially as the female population increased. So that in 1882, when I came to the field, Charters Towers presented the appearance of a considerable town, consisting mainly of two streets, Mosman and Gill streets, with numerous houses scattered more or less irregularly over the various flats: Rainbow Flat, along St. George Creek, Salt's Ridge, the Queen, and St. Patrick districts. The only two-story building then in existence being the Empire Hotel, and the population of the district reaching to between 5,000 and 6,000 inhabitants.

In 1882 a wooden hospital stood on the site of the present fine brick edifice, and was capable of holding about twenty beds; it was supplemented by the original hospital, which had been removed to this situation in 1873, and could accommodate about twelve patients.

In 1884 the present two-story brick hospital was opened. In 1888 a residence for a resident surgeon and a fever hospital were added to the building, and the first resident surgeon, Dr. de Vis, was appointed at the annual meeting in July of that year.

The sanitary condition of Charters Towers in 1882 was most deplorable. In the first place, all night-soil and refuse were deposited in cesspits, and these cesspits, in most cases, either overhung the various creeks, or were placed in rows on the flats. At night a miasma arose covering these flats, and hatching malarial fever; while, to any one passing between the rows of closets, the stench was unendurable. In the second place, when rain water became exhausted, which it did very rapidly in dry weather, the water supply was derived from wells, situated principally on the banks of the creeks. In almost every case cesspits were placed in close proximity to the wells; indeed, I remember counting four closets within a distance of one hundred yards from one well. In the third place, most of the streets, with the exception of Mosman and Gill streets, were at this time unformed; and the flats were cut up by channels through which the water rushed during downpours of rain; and when the rain was excessive, the water, escaping from the channels, overflowed the flats, inundating the cesspits and scat-

tering their contents over the surface of the soil. When, however, the rain continued and a general flooding of the district took place, a reformatory process ensued, the wells were thoroughly washed out, and the effete matter on the surface of the ground was carried by the floods down the creeks to the Burdekin.

From the foregoing description of the sanitary condition of Charters Towers in 1882, the conclusion to be drawn seems to me to be that epidemic diseases, especially typhoid fever, must be influenced very considerably by the rainfall of the district. That in dry years the water supply, being entirely dependent on wells so likely to be vitiated by the proximity of cess-pits, will in all probability prove a fruitful source of

enteric fever; that in years when the rainfall is considerable, but the surface flooding only partial, the amount of fever will increase both from greater drainage of impure material into the wells, and from the miasma arising from the surface of the soil; but that very heavy downpours of rain sufficient to carry away all source of surface poison, and to cleanse out the wells, will diminish very considerably the numbers affected by epidemic disease, this effect being supplemented by the increased amount of rain water for drinking purposes.

This view is, I think, substantiated by the accompanying table, shewing the rainfall and death-rate in each month in the years from 1882 to 1889 inclusive:—

Month.	1882.		1883.		1884.		1885.		1886.		1887.		1888.		1889.		Total.
	Rainfall.	No. of deaths from Typhoid.	Rainfall.	No. of deaths from Typhoid.	Rainfall.	No. of deaths from Typhoid.	Rainfall.	No. of deaths from Typhoid.	Rainfall.	No. of deaths from Typhoid.	Rainfall.	No. of deaths from Typhoid.	Rainfall.	No. of deaths from Typhoid.	Rainfall.	No. of deaths from Typhoid.	
January	9.94	..	1.47	..	1.82	6	1.49	1	1.44	2	2.20	2	2.10	2	.74	8	22
February	9.15	..	6.85	..	1.64	1	5.50	2	4.22	4	6.40	..	5.52	2	3.09	4	13
March	11.85	..	.78	..	2.88	4	.04	..	.50	2	6.15	..	.14	1	.96	14	28
April .. ..	.50	..	2.09	2	.09	4	.29	1	2.90	2	1.45	..	.1	2	6.33	1	12
May .. ..	.01	..	2.41	2	..	..	..	1	.17	3	.91	1	..	..	2.85	7	14
June	6.36	..	..	..	..	..	..	1	2.14	1	.92	..	..	1	.83	2	4
July	2.60	..	..	..	.30	..	..	1	2.34	1	.67	1	.14	..	1.26	3	7
August .. ..	..	..	..	2	..	1	.60	..	.65	..	.48	..	.16	1	.32	1	5
September ..	.48	..	..	1	.50	..	.41	..	4.04	..	..	1	.69	2	2.87	1	5
October	1.40	..	.49	1	..	1	..	1	1.13	..	1.08	..	..	1	..	1	5
November ..	1.67	..	2.47	..	.12	..	..	3	3.63	1	2.36	..	.06	4	5.30	..	9
December ..	6.30	..	2.29	5	5.71	1	2.17	3	9.33	..	5.4	1	4.11	3	5.28	..	13
TOTALS ..	42.16	..	19.05	15	13.08	18	10.86	13	31.79	24	23.43	6	13.02	19	29.88	42	137
Total rainfall for 8 years .. 189.27.																	Average .. 23.66.
,, deaths ,, ,, .. 137.																	,, .. 17.1.

In 1882, according to this table, the rainfall during the first three months of the year was excessive, amounting to nearly 24 inches. The whole country was flooded, the Burdekin bridge being impassable for several days. Again in June and July 8.86 inches of rain fell, and in December there was a further rainfall of 6.3 inches. The entire amount of rainfall this year reached to 43.16, and we find in consequence that not a single death is registered in the Charters Towers district from enteric fever.

In 1883 we find the December rainfall of 1882 supplemented by a rainfall of 7.72 inches in January and February, and it is not until April that mortality from typhoid appears, following the dry hot weather of March. In April and May a rainfall of over two inches in each month occurs—just enough to cause fermentation, yet not enough to cleanse—and we find during these months a mortality of four. Then follows a drought up to November; in this month and in December the rainfall resembles April and May with increased temperature, and in these two months six deaths are recorded from enteric fever.

In the first four months of 1884 the rainfall was insufficient for the wet season, and the typhoid death-rate amounted to fifteen. A drought then occurred from May to the end of November, with a record of three deaths. In December nearly six inches of rainfall was noted, with one death.

This heavy rain in December, 1884, was succeeded in January and February, 1885, by a rainfall of seven inches, with a consequent small mortality in the first four months of four deaths from typhoid. From this a

complete drought extended up to December, when 2.17 inches of rain fell. During October, November and December—that is during the hot months of drought—there was a mortality of seven from typhoid.

The small amount of rainfall in November and December, 1885, was followed in 1886 by a fall of only 1.64 inches in January, 4.2 inches in February, and .6 inch in March; and we find the large number of sixteen deaths from the same cause. From June up to December the rainfall was large and the mortality small, there being only three deaths recorded.

The rainfall of 9.33 inches in December, 1886, was followed by a very wet January, February and March in 1887, 15.75 inches of rain falling during the first quarter; and this flooding of the country cleared typhoid away to such an extent that only six deaths were recorded for the entire year as arising from enteric fever.

The rainfall of 5.4 inches in December, 1887, was supplemented during the first three months of 1888 by 2.1 inches in January, 5.52 inches in February, and .14 inch in March, with a typhoid mortality of five. A drought followed up to December, with a death-rate of fourteen. In December 4.11 inches of rain fell.

In 1889, in January, February and March, only 4.79 inches of rainfall occurred, and the weather was extremely hot, especially during March, and the great mortality of twenty-six deaths from typhoid were registered. In April a downpour of over six inches of rain occurred, followed by nearly three inches in May, and after these months the mortality diminishes. In November and December a rainfall of 5.3 and 5.28 inches

occurred respectively, with no deaths from typhoid; and in 1890 the heavy floods in the early part of the year have been followed by sufficient rain to keep up the supply of drinking water, and the cases of typhoid have been few and far between.

Now from this table it is evident that in 1882, 1887, and 1890, when heavy floods occur, the amount of typhoid is trifling; in 1884, 1886 and 1889, when the wet season of November, December, January and February failed, the death-rate from typhoid was very high; and that the amount was highest when there was sufficient rainfall for assisting putrefaction and fermentation in these warm months, but not sufficiently great to wash the surface of the soil and cleanse out the wells. During the years 1882 to 1889 the average total typhoid mortality of the seven warm months from November to May inclusive was nearly fifteen, whilst during the five colder months, from June to October, the average was only about five.

In connection with typhoid fever it may be interesting to trace the history of its treatment during the period embraced in this paper, at the Charters Towers Hospital. In 1882 the routine treatment was, if the case was in its first week, one or more initial doses of calomel, followed by small doses of quinine, two to three grains three times a day, with large doses—ten to thirty grains—in cases of hyperpyrexia, symptomatic and dietetic treatment being regulated by individual cases. In August, 1884, Dr. Mohs commenced a trial of salicylate of soda in hyper-pyrexia, and for some time used it in fifteen to thirty grain doses. The great disadvantage found in its use was its tendency in some cases to produce a form of mania much resembling that of *delirium tremens*. In January, 1886, antipyrin replaced the salicylate of soda as an antipyretic, and was largely used up to November, 1887, when it gave place, in its turn, to antifebrine. Since 1887 up to July, 1890, antifebrine in five-grain doses, and quinine in large doses—twenty to forty grains—were used as antipyretics by Dr. De Vis. Dr. De Vis believed in one large dose being given early in the morning. He held that by doing so you control the fever at the time when rise in temperature commences, and by preventing it reduced the temperature during the entire day. The cold bath treatment of Brand's has never been carried out in its entirety in the hospital, and amongst the mining population of the Towers it is impossible to use it successfully in private practice from the want of trained nurses, and until lately the necessary supply of ice; but I have found, especially in children, immense advantage from frequent cold sponging of the skin, from the wet pack, and from covering the abdomen with spongio-piline, wrung out of tepid water and frequently changed. My own experience of antipyretics is confined to quinine, antipyrin and antifebrine. In spite of Nothnagel's predilection for Thallin I do not think it has come into general use in Queensland. Of the three quinine in large doses, whilst slower in action, produces a much more prolonged depression of temperature, and has perhaps besides an antiseptic action; in children especially I prefer it as an antipyretic to antipyrin and antifebrine. When, however, we find the temperature not controlled sufficiently by quinine, or when the latter is badly borne; in fact in such cases as require a rapid decrease of temperature, I have found antifebrine especially of immense service, in many cases producing a most brilliant result. In cases of troublesome sleeplessness a combination of five grains of antifebrine with fifteen of urethane almost always succeeds in giving rest. Of the danger of cyanosis from the use of antifebrine, besides minor cases, I have had three marked examples, in all of which the dose given was

five grains. In two of these the patients recovered after subcutaneous injection of ether, administration of stimulants, and application of heat; in the third, that of a young plethoric female only a short time in the colony, I found at 11 a.m. on visiting late in the second week of the disease, a temperature of 105.2 F., and ordered five grains of antifebrine. About two hours subsequently her brother-in-law came down to inform me that she seemed to be very collapsed, and I took Dr. Paoli up in consultation with me, to find she had died a few minutes before our arrival, either from cyanosis, or from the shock of perforation, the latter view being possible, as there was marked tympanitis. Since then I never give more than three grains as an initial dose, and always give some stimulant after it. The cyanotic effect of antifebrine is mostly shown in the first few doses, the system subsequently accommodating itself to its action. Before leaving the subject of enteric fever I beg leave to touch on a few other points; the first of them, profuse hæmorrhage, of which I had several examples in 1888 and 1889. The treatment usually adopted in these cases was abstinence from food by mouth, ice bags to abdomen, and in severe cases iced water injections, with opium or morphia by mouth or hypodermically. In two cases these remedies failed to arrest the hæmorrhage, nor was the turpentine treatment more effectual, and death seemed imminent from collapse, when the hypodermic injections of sclerotic acid succeeded in stopping the mischief, both patients happily recovering. The next point is one that must have attracted the attention of such gentlemen present as have had much experience of typhoid in the old country, I refer to its example of the well-known law that any disease may assume a type resembling that of an epidemic prevalent in the district; that remittent fever is endemic here it is unnecessary to say, and I certainly have found, in not one but very many cases, great difficulty in diagnosing between typhoid and remittent fever. In a large number of cases the attack comes on with high temperature and great headache, no nose spots present, and no diarrhoea; in fact the symptoms resemble malarial fever, yet after some time typhoid declares itself unmistakably. In India the rule, according to G. Harrison Younger, is to suspect every case of continued fever to be typhoid until it can be proved to be not so; and I think the same rule may be adopted in Northern Queensland. Of all typhoid symptoms the ilio-cæcal tenderness and gorgement, either singly or combined, are perhaps the most constant; next to these the contracted tongue, red at the tip and edges, with a creamy fur on the surface, often becoming subsequently glazed or brown in the centre. The tenderness in the left hypochondriac region, and at the pit of the stomach in many cases point out malarial cases. The best tests, however, between the two are, as Massi pointed out in the *Gazette Medicale D'Algerie*, (1) the effect of nitric acid on the urine producing in typhoid an indigo diaphragm, accompanied in grave cases by a second white diaphragm of albumen, and sometimes by a third diaphragm of uric acid, each diaphragm being separated from the other by a bed of urine, while in remittent a brown diaphragm shows at the bottom of the glass, with in grave cases a diaphragm of albumen, and in cases of bilious remittent there may be a third diaphragm of the colouring matter of the bile; and (2) the results obtained from large doses of quinine. If a patient takes from ten to twenty grains of quinine three times a day without a marked permanent decline of temperature after a few days treatment, the case almost always turns out to be one of typhoid. Perhaps, however, when bacteriology becomes as widely known and as much practised as the use of the ophthal-

moscope and laryngoscope have during the last twenty years, much of the difficulty in diagnosing fevers will be solved by the microscopic examination of the blood. The other points, gentlemen, on which I wish to say a few words, are the advantages to be gained from caffeine and pepsin in typhoid. Caffeine I have found of decided service when low nervous symptoms appear, such as hiccough, subsultus tendinum, &c.; and in cases of typhoid with high temperature and marked diarrhoea, especially when milk curds appear in the stools, peptonizing the entire diet sometimes produces startling results. I use the word startling advisedly, as on one occasion the temperature fell from 105·6 to 98·8 in a few hours, leading me, from the rapidity of the fall in the absence of an antipyretic, to fear hæmorrhage.

On leaving the subject of typhoid, I may add that the influence of a prevalence of malaria on other diseases has been especially taught me at Charters Towers in cases of diseases of children: patients that in England I treated with salines, calomel, or James' powder, here yield at once to quinine. I have repeatedly noticed in cases of infantile convulsions, that when recurrent, each attack is preceded by a rapid rise of temperature, and that while the usual remedies of potas. brom., chloral, and valerian, with hot bath and turpentine injection, relieve the attack, that quinine, by keeping down the temperature, prevents its recurrence.

In the early months of 1885, Charters Towers was visited by an extremely severe epidemic of malarial fever; in fact, so prevalent was it, that to escape proved the exception and not the rule. In most cases the attack was sudden with a very high temperature; in many it assumed the form of bilious remittent, but in no case, to my knowledge, was it fatal. The epidemic, indeed, was solely remarkable for the number of victims attacked.

In November, of that year, the single pan system of getting rid of the night-soil was gazetted as to come into force over the entire municipality; but it was not until 1887 that the system was rigidly carried out. From 1884 up to 1887 the principal streets embraced within the municipal boundary were formed, and the surface water drained by proper channelling. Although not an advocate of the single pan system, which I consider most defective, yet I must confess that in consequence of these improvements there has been a decided decline in the number of typhoid cases occurring within the municipality proper; the majority of the typhoid fever cases that have been under my care since 1887 being residents of the Rainbow, Salt's Ridge, St. Patrick, and other districts, where the old cesspool system continues with its accompanying miasmatic stench. A water supply from the Burdekin is fast approaching consummation, and will, I hope, be finished before the end of the present year.

In 1888 I had an opportunity in four simultaneous cases of trying Kremianski's aniline treatment of phthisis. Two cases were patients in the third stage of the disease, with vomica in both lungs, profuse expectoration, and considerable hectic fever, one 17, the other 35 years of age. In the other two cases, occurring in early manhood, there was merely wasting, slight dulness on percussion below the clavicles, hæmorrhage on various occasions, prolonged expiration, and troublesome dry cough. In all these cases I gave five grains of acetanilide twice a day, with inhalations of oleum anili three times a day. In the patients in the more advanced stage the treatment for some time seemed to give marked relief, the expectoration decreasing, the hectic fever falling, the cough abating, and the appetite improving; but after continuing it, in one

case for two months, in the other for seven weeks, as I found the strength and appetite no longer getting better, but the reverse, I was reluctantly compelled to come to the conclusion that its further continuance was inadvisable. In the two cases in an early stage of phthisis the treatment proved still more disappointing, the diaphoresis weakening, but not benefiting the patients. In these latter cases, I believe, decided benefit was obtained for a time from the inhalation of menthol. Of the various inhalations recommended for phthisis I have found material advantage from only two, or if we include menthol, three; viz.: iodine vaporized, and creosote diluted with spirits of wine and inhaled by means of the naso-pharyngeal inhaler. Of internal remedies, the hypophosphites, arsenic, and cod-liver oil in the early stage, if combined with climatic treatment, in many cases arrest the disease; but I fear we can do little when it is an advanced stage, until bacteriology suggests a means of destroying either the bacillus of phthisis or the pabulum on which it thrives.

In 1889, and in the first half of the present year, I met with a considerable number of cases of diphtheria and diphtheritic croup, and, so far as my experience goes, I am prepared to speak most highly of the turpentine method of treatment. I gave ol. terebinth in from 10 minims to drachm doses, internally, three to four times a day; and at the same time adopted Schinkel's plan of mixing six ounces tar with two and three quarter ounces turpentine, and burning the mixture at regular intervals during the 24 hours. In 17 cases in which the disease was unmistakable, the membrane being markedly present, accompanied by enlarged cervical glands, &c., the treatment failed to arrest death in only three cases; and even in these I believe it might have succeeded if adopted earlier in the disease, all being cases to which I was called when the respiration had become embarrassed, and when the patients died from exhaustion during the succeeding 24 or 48 hours. I may add that in no case when Schinkel's plan was adopted early enough did the disease spread amongst the other children in the family.

In this year also, an epidemic of catarrhal jaundice occurred throughout this district. Its origin seems to be from some atmospheric cause, as it attacked both sexes, and was not confined to any class or special locality. My attention was directed in this epidemic to the frequency with which it attacked pregnant women, and its tendency, in the latter months of pregnancy to produce premature birth, by a case to which I was called two days after childbirth, in which death apparently arose from cholemia. When first seen the patient was intensely jaundiced and comatose, with great tympanitis, but no rise in temperature, and from the history given by the nurse, no symptoms of metritis preceded, a gradual development of muttering delirium followed by coma. In this epidemic I had several other cases of cholemics under my care. In these, both vomiting and constipation proved most troublesome, accompanied by great prostration, with more or less fever and lowness of spirits, followed by low muttering delirium resembling that of delirium tremens. The hypodermic injection of pilocarpine in such cases gave marked relief, and the vomiting and worst symptoms rapidly disappeared when the bowels were kept acting.

Of the value of euonymin as a cholagogue I received satisfactory evidence during this epidemic. When combined with small doses of calomel or podophyllin, and followed or accompanied by nux vomica and either the dilute nitro-hydrochloric acid or an alkali, the effect produced in a few days was often striking. In some cases the jaundice proved obstinate, continuing for weeks; and in these the action of euonymin and the

mineral acids seemed to be improved by the addition of tincture of jaborandi. Where sleeplessness presented itself as a distressing symptom, conium proved to be very beneficial, and in some cases in which itching of the skin proved troublesome, relief seemed to be gained from bromide of potassium.

Dr. Forbes, on his arrival at Charters Towers in July, 1889, as Resident Surgeon to the Charters Towers District hospital, introduced the dry boracic acid treatment of wounds. I am not speaking too strongly when I confess that I was astonished at the success to be derived from it. Wounds of every description and extent healing up by first attention, in many cases the original dressing being retained until the cure was perfected. In every case perfect sweetness resulted for several days, the dressings being consequently few and far between.

During the eight years that have elapsed since I first commenced practice in Charters Towers, I have met with an unusually large number of cases of inflamed inguinal lymphatic glands, these buboes arising apart altogether from venereal disease. If you get one case it is generally followed by several others, so as almost to seem an epidemic. In some cases the patients ascribe the swelling to a strain, but generally appear to be unable to account for it. The glands of one groin may alone be affected, or they may be swollen on both sides. They generally subside without suppuration if taken in time and not aggravated by heavy walking or riding. These buboes are so common in North Queensland as popularly to be termed "Northern Lumps."

Speaking of buboes naturally brings me to the subject of syphilis. During my residence here I have never seen what I would term a typical hard chancre, with its scanty secretion and marked induration. On the other hand many cases of multiple worm-eaten greyish ulcers, sometimes sloughing, and often accompanied by buboes, that I would in England have looked on as soft sores, I find here in the majority of cases followed by secondary and unmistakable symptoms of syphilis. In most cases where buboes are present they do not suppurate; indeed the suppuration of the buboes I always look on as favourable to the probability that the disease is not true syphilis.

The phagedenic ulcer is by no means uncommon, many cases especially coming in from the bush with a penis that, if it does not drop off in its entirety, at least bears heavy scars for the remainder of its days.

During the past two years I have seen many of the old identities depart for, it is to be hoped, the cooler regions. Those to whom I especially refer at present were men who in their early career worked early and late in their pursuit of the yellow metal. Their efforts became crowned with success, and they eventually made a larger or smaller pile. With plenty of money and leisure at their command they drank considerable quantities of alcohol, to find, however, in the end, that they could not retain their health, drinking the amount they could stand with impunity when they were accustomed to work it off by severe muscular exertions. In a few years their constitutions gave way, and when such was the case I have noticed in almost every case that the first marked warning given, the first weak point complained of, was in the legs, first a feeling of coldness or numbness, followed after a time by muscular weakness, and finally by dropsy. In most cases the patients' livers were probably fatty or cirrhotic, or their kidneys diseased, but the usual remark to which I have been accustomed was, "if my legs were strong I would feel all right."

In conclusion, gentlemen, I beg to enter my protest against the supineness of the municipal authorities and

divisional boards in North Queensland on the subject of sanitary reform. At a discussion held at a meeting of the municipal representatives of Charters Towers when the double pan system was advocated, it was objected to by some of the members on two accounts, firstly the expense, and secondly that it was useless for the municipalities to make sanitary reform when nothing had been done by the divisional board. Again, last year, the latter were requested to appoint a sanitary officer, and they refused to do so, because they did not consider it necessary; and this at a time when the death rate from typhoid during the previous year amounted to 42.

Might not the North Queensland Medical Society beneficially commence its career by appointing a committee to gather from the various members of the society their individual views on the means of sanitary reform best suited to each district? If this be done, and the results endorsed by the society, such steps may be taken as may be necessary to lay the views of the society before parliament with a favourable prospect of intelligent legislation on the subject in the immediate future.

I am certain that if a responsible officer had been appointed on this field, whose duty it was to carefully examine periodically the various wells from which water is carted for the use of the public, and to close those in which albuminoid ammonia exists to a dangerous extent, that typhoid fever would have been much more rare, and many valuable lives saved.

Perhaps the strongest weapon we can wield against bad sanitation is the diffusion of the necessary knowledge on sanitary matters amongst the rising generation; and I would strongly advocate that plain lessons on this matter should form a prominent subject in state school education.

I will now conclude, gentlemen, this rather diffuse paper by once more thanking the visiting members of this society for their attendance here to-night, and I hope that these meetings will tend to draw the medical brethren in North Queensland into a united band that will work together for the benefit of medical science, and for the good of their adopted land.

DR. HUMPHREY thanked Dr. Browne for his very able paper. In typhoid fever he believed the best treatment was to do as little as possible; to watch the pulse and give brandy when indicated was one of the most important items in treatment. In hyperæmia he gave quinine in five grain doses every four hours, and ordered tepid sponging every two or three hours as it was nearly always impossible to give baths in private practice. A handkerchief frequently dipped in iced water to the head he had found reduce the temperature a degree or so. As regards hæmorrhage he always administered an enema of Tr Opii ʒss Starch ʒi, and seldom found it fail. Gurgling in the right iliac fossa he considered of little value for diagnosis. Swelling of the glands in the inguinal region he had frequently seen, both in Mackay and Townsville, without any vesical or other apparent cause. The first one or two he had opened, feeling convinced from the appearance and sense of fluctuation in the swelling there was pus, but was much surprised not to get any, or if any only a drop or two; the incisions had certainly been of no benefit. In one case an old bushman of North Queensland, a friend of the patient, had laughed at him for doing so, he seemed well acquainted with "Northern Lumps." He thought it probably related in some way to the malarial fever, as in almost every case the patient had had it within the twelve months previous. It was generally accompanied by anæmia. His present treat-

ment was a generous diet and tonics and blisters applied locally, and when it was possible a change of climate for a time.

DR. FORBES observed that in his hands also antipyrin and antifebrin were but temporary in their influence, while quinine was more permanent, and was vastly superior in its effects upon circulation as observed in the beneficial results in the pulse rate. Of course there was nothing better than the cold bath when feasible. The above remarks referred to the treatment of hyperpyrexia. He also considered that as a means of diagnosing between typhoid and malaria the cold bath was useful, as in the latter its use caused the temperature to rapidly go down, and in being taken out of the bath it went up just as high again in a very short time.

DR. BROWNE replied that he thought gurgling was useful only as corroborative evidence in the event of a question between typhoid and malaria. Typical cases of the former were rare, and rose spots seldom seen. He invariably gave large doses quinine (15 grs.) in remittent fever. He also observed that his experience seemed to point to delirium being more common at home than out here.

Dr. HUMPHRY then read his paper on "A case of Oophorectomy" as follows:—

REMOVAL OF OVARIES AND FALLOPIAN TUBES FOR UTERINE FIBROID, WITH MENORRHAGIA—TETANUS—DEATH.

By ERNEST HUMPHRY, L.R.C.P., M.R.C.S.E.

Mrs. B., aged 32. Married at 18. Five children, youngest four years old. Natural labours. Catamenia commenced at 15, regular, and in natural quantity.

June 15.—Fourteen months ago she had a miscarriage, with severe flooding, lasting several days. Three weeks after, the nearest doctor was sent for, 30 miles away, who removed some adherent membrane, or after-birth as she called it. The doctor told her it was a three months' abortion. The hæmorrhage still continued, and so she was brought to Townsville and placed under the care of Dr. Frost, who, under chloroform, removed some more membrane, about half-an-inch thick; at the same time, he felt a convex surface at the fundus of the uterus which he was unable to remove. The hæmorrhage then ceased, and she went back to the country. After her return she suffered from profuse menstruation, lasting 10 days and increasing on the slightest exertion. She became very weak and pale. For the last six months she has kept her bed continually, as the hæmorrhage increased at each menstrual period, coming on most severely on the second day, so severely, in fact, that her country doctor had to plug the vagina. Three months ago she went to the hospital, and remained there till she came under my care. The vagina was plugged at every period.

I saw her immediately on her arrival by steamer. At that time she was very blanched, having lost a large quantity of blood on the way down.

June 17.—Dr. Frost saw her in consultation with me.

Abdomen flat and soft. Two inches above the pubes a hardness could be made out; it was quite moveable and easily defined; dull on percussion.

Per Vaginam.—The cervix was slightly eroded, but otherwise natural; it looked directly backwards. Bimanually, the hardness over pubes and the uterus was found to be the same; it felt about the size of a large orange and was freely moveable; sound continued 2½ inches; still having considerable amount of hæmorrhage.

After the examination, we came to the conclusion she was suffering from fibroid of the uterus. Dr. Frost, who had seen her 12 months previous, said the uterus had much increased in size. Otherwise, she was in good health, the pulse keeping at about 100. She was anxious to have something done, as her life was useless, and she was continually in fear of bleeding to death. She had been unable to get out of bed for six months. Violent hæmorrhage always came on immediately, the periods even lasting for three weeks or more now, with always severe flooding on the second day, and each time became worse.

July 1.—At this date the loss was slight, and the heavy loss was not expected till the 8th of this month.

Dr. Van Someren administered chloroform, and Dr. Frost assisted me with the operation. I made an incision 2½ inches long, and removed the ovaries and fallopian tubes, having first transfixed the pedicle and ligatured with silk. There was very little hæmorrhage, and the appendages were quite free from adhesion. The operation lasted about half an hour.

July 5.—She has done well since the operation. One or two injections of morphia were given to relieve pain. Temperature never rose above 100°, and the pulse has varied from 96 to 110. Tonight she feels very comfortable; temperature, 101°; pulse, 120. Nothing to account for the rise in temperature.

July 8.—Has kept very comfortable till this morning: the temperature has been up to 101° every evening since last note. This morning it pains her to eat; is afraid she has lockjaw. No stiffness of the neck or rigidity of the masseter muscles to be felt.

4 p.m.—Marked rigidity of the masseter muscles; unable to protrude the tongue.

12.—Tetanus rapidly developed, in spite of calabar bean in large doses and injections of morphia. She was unable to swallow or retain any-

thing by the bowel on the second day, and any attempt at passing an oesophageal tube caused such violent paroxysms that I considered it wiser to desist.

Remarks.—This case, I have every reason to think, would have had a successful result if it had not been cut short by tetanus. Two other courses of treatment were considered, one Apostoli's, and the other enucleation. The patient had been ill so long that she was tired of being an invalid, and she wished to be killed or cured. Apostoli's method would take so long, and with such a doubtful result that I put it on one side, as I don't think she would have submitted to it. The enucleation of the fibroid was put out of the question, as I considered oöphorectomy the safer and surer method. I am sorry I was unable to make a *post mortem*.

DR. BROWNE remarked that if circumstances had allowed of it he would have liked to have seen enucleation tried first of all, especially as it might have been a pedunculated fibroid. The absence of a *post-mortem* was unfortunate. Considered that the best course for the patient, under the circumstances, was adopted.

DR. FORBES said Apostoli's treatment was all very well for metritis and in metrorrhagia from passive congestion, but would have been useless here, and that the operation adopted was the only course open.

This concluded the proceedings.

NEW SOUTH WALES BRANCH OF THE BRITISH MEDICAL ASSOCIATION.

THE 92nd General Meeting of the Branch was held at the Royal Society's Rooms, Sydney, on Friday, 1st August, 1890. Present:—Mr. G. T. Hankins, President, in the chair; Drs. Jenkins, Fiaschi, Hodgson, Clark, Rennie, Knaggs, Rorke, McDonagh, West, Megginson, Clubbe, Martin, Fieldstad, MacSwinney, Huxtable, Lyden, Maher, Parker, Kendall, Bowman, G. A. Marshall, Cohen, W. J. O'Reilly, Crago, Wm. Chisholm, Newmarch, and Worrall.

The minutes of the previous meeting were read and confirmed.

The PRESIDENT announced the election of the following gentlemen as members:—Drs. Beattie, Collins, R. Bowman, MacSwinney.

DR. CLARK exhibited a patient upon whom he had performed Gastrostomy for malignant disease of the oesophagus.

The PRESIDENT considered that Dr. Clark should be congratulated on the success of his case. He (the President) thought the success was attained by operating at an early stage of the disease. The last case he had treated in the Prince Alfred Hospital terminated fatally solely because of the extreme state of exhaustion of the patient before the operation. The *post-mortem* showed that the adhesions were perfect, and that the man sank simply through inanition. The stomach was opened by means of an aspirating needle, and the patient was fed in that way. Concerning the method of fixing the stomach, Dr. Clark had stated that he had used hair-lip pins instead of sutures. He (the President) would have thought that hair-lip pins would have been quite as likely to wound vessels. He thought in cases of the kind indicated the plan recommended by Dr.

Fergusson was worthy of trial, in which the external coat was kept up by pressure forceps, the points being guarded by indiarubber tubing.

DR. RENNIE exhibited a case of sporadic cretinism.

NOTES ON A CASE OF SPORADIC CRETINISM.

By GEORGE E. RENNIE, M.D. (LONDON),
M.R.C.S. (ENGLAND).

CASES of Sporadic Cretinism are sufficiently rare to warrant my bringing this case before you this evening. Dr. F. N. Manning informs me that he knows of only two other cases in New South Wales. The patient, S. F., is a boy aged four and a half years. The family history is as follows:—His mother has been deaf and dumb since early years, but was not born so; her father and mother were both natives of Scotland, and were not related; all the family were strong and healthy. Father also is healthy; his parents were also Scotch—natives of Dundee; his family also were strong and robust. The patient is the youngest but one of six children; all the others are healthy and strong. There is no history to be obtained of any nervous affection, insanity, epilepsy, goitre, or syphilis in any of the patient's relatives or connections. Nothing unusual happened during the time the patient's mother was pregnant with him. Patient was, as far as can be made out, a strong and healthy child until about the age of 10 months; at that time he had an accident, which resulted in a "green stick fracture of the shoulder blade" (?) (the father states that the doctor distinctly told him that this was the nature of the accident.) From that time the child seemed to cease growing and developing, both bodily and mentally, for at least 18 months. For the last six months, the father thinks he has shown signs of improvement.

The patient presents all the leading features of cases of this form of idiocy, viz.:—pale, heavy face, chronic inflammatory lesions of eyelids, flattened nose, thick lips, large tongue, carious teeth, thin coarse hair, short neck, absence of thyroid gland, supraclavicular swellings, very prominent abdomen, with back much curved inwards, large upper and lower limbs, broad swollen thick hands and feet, rough skin. There are no signs of rickets, or of congenital syphilis. General health is good, his only trouble being obstinate constipation. His mental symptoms are few; he can say a few words, such as "no," "don't," "go away," &c.; never asks for food, he only makes signs for it. Very slow in movement, and makes no attempt at imitation; generally good tempered, but occasionally is passionate though not destructively so.

DR. CLUBBE also exhibited a patient suffering from sporadic cretinism, who, he stated, was 20 years of age. Only meagre particulars were available concerning the patient's history. He had been met with in Randwick Asylum, and the Superintendent had asked him (Dr. Clubbe) to express an opinion as to the ability of the young man to work. The height of the patient was 4 feet 6 inches, and the marks of cretinism were rather typical. He had the broad eyes, thick lips, protuberant stomach, rough skin, and although not idiotic the patient was not intelligent. He (Dr. Clubbe) thought it of some interest to bring the case before the meeting.

DR. CRAGO observed that three months ago a case came under his notice, which he did not at the time recognize as one of cretinism, though from photographs of cases he had afterwards seen in the Medical Congress papers he came to the conclusion that his case was one of the same class. The patient—a girl probably about 18 years of age—presented the usual typical signs. Her lips were very thick indeed, she was diminutive in size, and decidedly idiotic.

DR. KENDALL read a paper on Electro-therapeutics, which will appear in our next issue.

DR. HODGSON, in referring to his experiences in electricity which had been confined to Urethral strictures, remarked that his results were generally favourable, and those cases in which it had been tried were certainly much benefitted. In the suburbs of Sydney he found there was very little urethral disease, but he supposed the Sydney doctors could hardly say the same. Consequently he had not used electrolysis in this colony, but the applications conducted in England yielded results which led him to highly recommend the treatment in similar cases, as it was far preferable, and more permanent than effecting dilatation by means of bougies in the ordinary way.

DR. WORRALL observed that he thought it would have been of greater value to the meeting if Dr. Kendall had described his method of applying the electricity. For instance, in the case of erosion of the os uteri, it would have been as well to state how the electricity had been applied, and it would also have been interesting to know the nature of the erosion, whether there was lacerated cervix, or whether the cases were due to glandular proliferation. In enuresis much would depend upon the cause, many cases in parous women being due to dislocation of the urethra, which only operation could remedy. The affection for which electricity was considered the remedy par excellence was uterine fibroid. Many who at first had advocated it for this, had now given it up. He (Dr. Worrall) rarely, if ever, felt the necessity of employing electricity.

The PRESIDENT said that there was no doubt that occasional discussion upon this subject stimulated one to renewed exertion. He had had many attacks of enthusiasm, but they had always cooled down. He took a great interest in the practical development of the matter, and when he heard of a series of successful cases he felt tempted to begin again. It was a costly process, however, and unless one could, with confidence, promise success, one could not hope to induce patients to undergo a prolonged course of electrical treatment. Electricity formed a useful purpose in the matter of diagnosis. As to the practical application of electricity, he desired to place before the meeting some electrodes which he had improvised: instead of using sponge or flannels, a fleshy piece of lint could be substituted, and described what was a modification of the ordinary blotting pad.

DR. KENDALL, in reply to Dr. Fiaschi, said that the electro used was equal to a No. 6 catheter,—the size of

the stricture would not admit a No. 1 catheter. In reply to Dr. Worrall, he might say that the positive pole of the battery was applied to the erosion of the os, the other on the perineum, and in no case was there much laceration.

DR. NEWMARCH read a paper on intubation of the larynx, and exhibited a membranous cast of the trachea and bronchi. He afterwards remarked that the operation, by itself, was easily performed, and the relief given was certainly marvellous. He regretted taking away the tube; but after the *post-mortem* was made he felt convinced that whether the tube had remained in or not the child would have died. Instances were given in the *British Medical Journal* where casts had been spat out. This, however, could not occur with casts of the kind he exhibited. The question of feeding the child was a very serious matter. Dr. O'Dwyer had advised that the child be placed with its head far back, and that no liquids should be given at all. The specimen he would now exhibit would show how he (Dr. Newmarch) failed to get the child to drink.

DR. HODGSON said the last paper should awaken comment, and that we should be given minutiae how to conduct cases. Unfortunately we were all familiar with death in cases of diphtheria, and the fatal results of treatment by tracheotomy. It was a question whether relief and assistance could be rendered without recourse to the severance of the tissues. Concerning the *modus operandi*, we had been led to assume that it was simple and easy, but from reports he had read, Dr. Hales had stated that there was some difficulty in the process. In one of the cases recorded, this doctor stated that having made several ineffectual attempts to remove the tube the child's parents said to Dr. Hales "You placed the tube there—take it away again."

DR. NEWMARCH illustrated the method of fixing the tube, and explained that it was threaded with a piece of silk. For the purpose of taking the tube out, there was an extractor, which rendered its withdrawal very easy. It was necessary to use the gag.

DR. WORRALL desired to know whether the patient was under chloroform, and received a reply in the negative.

DR. CLUBBE failed to see the advantage of intubation in diphtheria. In cases of simple laryngitis it would be of use, but not in diphtheria. Dr. Hales had given the result of his treatment of 100 cases. Of these he had saved only 38, which was indeed a bad record. The records for tracheotomy showed that 60 per cent. at least were saved. The advantages of intubation were well put by Dr. Mackenzie. He said you readily obtain the consent of the parents who had a horror of their children's throats being subjected to the operation of tracheotomy. In intubation you are liable to push the membrane in front of you, and there was a danger of suffocation as you could not see what was going on. All of a sudden the tube gets blocked, and the child dies. He should like to know why Dr. Hales let 60 cases die without doing tracheotomy. If tracheotomy was performed, you could locally treat the trachea and remove membrane. If we have cases of diphtheria, tracheotomy should be performed directly laryngeal symptoms manifested themselves. In the last case he had treated, when the trachea was opened he found membrane just below, which he had dissolved with trypsin. In private practice one met with difficulties with regard to the interference of parents that should not be encountered in hospital practice. In order to save the child's life he considered it necessary to operate directly upon the appearance of laryngeal symptoms. If, upon opening the trachea, membrane were discovered, it would be well to wash or swab the

same with perchloride so as to prevent the membrane spreading downward.

DR. BOWMAN had a case similar to those mentioned by Dr. Newmarch. About 7½ years ago he had attended a child for diphtheria and had found a little membrane in the throat. The patient showed difficulty of breathing. He happened to have with him a little ipecacuanha wine, and administered two teaspoonfuls. The child in 15 minutes began to vomit. He subsequently discovered a perfect cast of trachea, and had the same preserved till it became dry. It was quite as solid as the sample exhibited. With local application to the throat the child recovered, but diphtheritic paralysis afterwards appeared. The facts he had adduced showed that it was possible for membrane to be thrown out in the effort of vomiting.

DR. CRAGO said that he had never tried intubation. The meeting were indebted to Dr. Newmarch for his information. Dr. Lennox Browne had said that he had had many successful cases, and that he was now in favour of intubation though formerly opposed to it. He (Dr. Crago) thought with Dr. Clubbe that it was to be regretted that the friends of the patients would not more readily consent to tracheotomy, as more command of the disease could be obtained by this method of treatment. With regard to the particular case referred to by Dr. Newmarch, that gentleman need have no regret that tracheotomy was not resorted to, as it would not have been successful in the case of so young a child. He had read that in the cases of very young infants only three cases out of a hundred were successfully treated by tracheotomy.

The PRESIDENT having explained that Dr. Crago's paper would take some little time to read, and that the hour was late, the meeting decided to adjourn.

NEWCASTLE MEDICAL SOCIETY.

THE usual monthly meeting of the above Society was held at the Newcastle Hospital on the 10th July. Present—Dr. J. B. Nash in the chair, Drs. Williamson, Harris, Nickson, Bonnefin, MacDouall, Hester, Ludlow, Stapleton, Ward, Eames, Morgan and Beeston.

The minutes of the previous meeting having been read and confirmed, a letter was read from Dr. Morgan tendering his resignation as Secretary to the Society on account of leaving the district. It was proposed and seconded that the resignation be accepted, and that a vote of thanks be accorded Dr. Morgan for the interest he has always shown in the Society. Dr. Morgan replied in appropriate terms and requested that he might be elected a corresponding member of the Society. This was carried *unanimously*.

Dr. Hester proposed and Dr. Bonnefin seconded that Dr. Beeston be appointed Secretary to the Society. Carried. Dr. Hester acknowledged on behalf of the Society the receipt of some periodicals, the gift of Dr. Morgan. Dr. Morgan read some observations on two cases of Spontaneous Version.

Dr. Beeston then read a paper on Obstetrical Statistics which was followed by an animated discussion, all the members taking part. Dr. Beeston replied.

Dr. Clarke, of Hamilton, and Dr. Moore, of Wallend, were elected members of the Society.

Pathological specimens were exhibited. A curious example of ante-mortem clot in the heart by Dr. Hester; a specimen of Syphilitic gumma of the Liver was shown by Dr. Eames.

The meeting then terminated at 10 p.m.

A MEETING of the Newcastle Medical Society was held in the Newcastle Hospital on Friday, 15th August, 1890. Present—Dr. Nash, President, in the chair, Drs. Meredith, Eames, Smith, Bonnefin, Stapleton, Nickson, Williamson, Treloar, Clarke, Harris, Hester and Beeston (Hon. Sec.).

Dr. Harris read a paper on Traumatic Tetanus which was followed by a discussion in which Drs. Beeston, Stapleton, Williamson and Bonnefin took part. Dr. Harris replied.

Dr. Treloar moved, "That the Secretary be empowered to communicate with the Secretary of the Western Medical Defence Association with a view of the Northern District amalgamating with the Society."

Dr. Hester seconded, and after a long discussion in which all present expressed their concurrence with the movement, the motion was carried.

THE WESTERN MEDICAL ASSOCIATION.

THE Ordinary Monthly Meeting of the Western Medical Association was held in the Town Hall, Petersham, on Tuesday evening, August 12, 1890. Present:—Dr. McSwinney (in the chair), Drs. Bowman, Hodgson, Kendall, Simpson, McNeill, Clune, Furnival, Quaife, R. T. Jones, Allan, Worrall, Browne, Hinder, Wood and Coutie.

Dr. Gardner was present as a visitor.

DR. HODGSON gave notice that he would move at the next meeting "That the Association adopt a scheme to deal with defaulting patients."

The scheme drawn up was read, and will be considered at the next meeting.

DR. REGINALD BOWMAN read a paper on Puerperal Eclampsia, which will appear in a future issue. In the discussion which followed, Drs. Clune, Kendall, Worrall, Quaife, Hodgson and Gardner took part.

Since last report thirty-two (32) gentlemen have been elected honorary members, bringing up the number of members and honorary members to one hundred and eighty-two (182).

A letter has been received from Dr. Beeston, hon. sec. Newcastle Medical Society, stating that it is the intention of the medical men in the Newcastle district to form a medical defence union, owing to the action taken by the friendly societies there, and asking for the co-operation of the Western Medical Association.

The Council, after due consideration, adopted the following resolution:—"That the letter be received; that the Newcastle medical men be congratulated on their determination; that it be suggested that they form a branch, not of the Western Medical Association, but of an embryonic Central Association; and that it be respectfully suggested that they adopt the same rules as the W.M.A., but fix their own fees for medical attendance."

It is intended to affiliate the two Associations when the Newcastle Society is formed.

A letter has also been received by the Council from Dr. Edwards, Waverley, stating that steps will be taken towards the formation of an Association in the eastern suburbs, and asking for the support of the W.M.A. It was decided to aid the movement, and that representatives from the Association should attend the meeting to be held in the eastern suburbs.

NOTICE.

The Editor will feel obliged by any gentleman, who wishes to ventilate any subject of professional or public interest, writing an editorial or leading article on its which if found on perusal to be consonant with the policy of the paper, will be inserted in an early number.

All communications intended for the Editor should be sent to the 'A. M. Gazette' Office, 35 Castlereagh Street, Sydney.

** * Contributors can have their Papers reprinted and published in Pamphlet form, at Cost Price, if the necessary instructions are given to the Publisher at the same time the contributions are sent in.*

AUSTRALASIAN MEDICAL GAZETTE.

SYDNEY, SEPTEMBER 15, 1890.

EDITORIALS.

LEPROSY AMONGST THE EUROPEAN POPULATION OF AUSTRALIA.

THE recent discovery of two more cases of leprosy, the subjects being white natives of New South Wales, is a matter of much interest to the health authorities of Australasia. There are now four European lepers segregated at the leper hospital for New South Wales; and there are doubtless other cases yet to be reported in this colony and probably in the others, for there is nothing peculiar to the Mother Colony which should cause the spread of leprosy to be confined to its population and to avoid that of its daughters. We fancy the reason that cases have been earlier discovered in it, is due to the more effective organization of its health department than in the other Colonies. We are of opinion that there is no cause for unreasoning alarm, but that it is undoubtedly the duty of the Government to give immediate and effective attention to the recommendations of the Board of Health, and to introduce such legislation as will legalize the segregation of the unfortunate sufferers, so as to confine the possible sources of infection to one spot, instead of allowing isolated cases to remain in various places amongst the people. At present there is no law empowering the removal from their homes and the confinement of the lepers, and

that it is now done is due to the tact and firmness displayed by Dr. Norton Manning, the medical adviser to the Government, and by Dr. Ashburton Thompson, the Chief Inspector of the Board of Health. On the face of it, it would have seemed that the circumstances of life in Australia would be especially unfavourable to the spread of leprosy, and minute investigation into the circumstances of life surrounding the unhappy victims of European descent will be labour well bestowed in the public interest.

THE NEW SOUTH WALES MEDICAL BILL.

THE Medical Bill introduced in the Legislative Council of New South Wales by the Hon. Dr. Bowker, came on for the second reading on August 7. The bill as introduced was apparently considered by the House to be so wanting in many particulars that it was considered advisable to refer it to a Select Committee with a view of remoulding it. This reference was made on the motion of the Hon. H. J. Tarrant, F.R.C.S.; and the members of the committee, in addition to the mover, are the Honourable Messrs. Bowker, Creed, Jacob, Mackellar, O'Connor, Pigott, F. B. Suttor, and W. H. Suttor. Dr. Bowker has been elected chairman.

The evidence taken by the Select Committee of the Legislative Council appointed in 1887, on the motion of the Editor of this journal, was so comprehensive that the work of the present Committee may well be confined to calling one or two witnesses to give evidence as to an evil which has risen into prominence since the former committee made its report,—we mean the numerous instances in which quacks advertise under the names of men absent from the country, dead, or having no existence; and further to so remodelling the bill that it will pass the Legislative Council without discussion, when it will be forwarded to the Legislative Assembly with some chance of its becoming law this session, provided the pledge given to Mr. Ewing, on withdrawing his resolution in that House in favour of the introduction of such a bill by the Government that every facility would be given and aid afforded to the private member having charge of a medical bill in that House, be kept.

LETTERS TO THE EDITOR.

AN AUSTRALASIAN MEDICAL ASSOCIATION.

(To the Editor of the A. M. Gazette.)

SIR,—Nearly three years ago Dr. Verco, at the close of his learned Presidential Address to the first Australasian Medical Congress, pointed out the advantages the profession might derive from concerted action and hinted at, rather than specified, a federation of the profession throughout the Colonies. His suggestions, though not yet acted upon, have never been forgotten; still, so far as I know, no steps have been taken to bring about any closer union of the medical profession in the different colonies. Members of the profession each in their own particular colony have their own local societies or branches of larger associations, but there is no correspondence between them and no bond of union. Yet there seems no valid reason why medical men practising in the different provinces of Australia should centre their scientific work and their professional sympathies in their own particular colony, tacitly ignore their brethren beyond the political boundary, and cultivate no closer relationship than is afforded by a Triennial Congress.

The very facts of the wide distances separating the various capitals, and the comparative isolation of large numbers of inland country practitioners make it the more desirable that one common bond of union should unite the whole profession throughout the whole of the colonies for objects of common instruction and common advancement.

I wish, Sir, through the columns of your Federal Gazette to advocate the formation of an Australasian Medical Society on the lines of, or preferably, affiliated to, the British Medical Association.

Such an Association with branches in the various Colonies and districts would provide the necessary machinery for the easier conduct of general congresses; for the joint publication of the transactions of societies; the simultaneous discussion of subjects affecting the interests of the profession; and might in the near future, by official connection with such a journal as that you now conduct, bring before its members a full record of all medical matters. The unprecedented success of the British Medical Association (to which so many of us owe dutiful allegiance) is mainly, perhaps, a consequence of central government and a journal—the common property of the Association.

Has not the time arrived when the profession in Australia should form a similar association and found a common journal?

I am, Sir,

Your obedient servant,

BEN. POULTON.

North Terrace, Adelaide,

August, 1890.

INFLUENZA DISCUSSION.

(To the Editor of the A. M. Gazette.)

SIR,—The report furnished you of my reply in the discussion at the British Medical Association states that I asserted Dr. Marano and Dr. Crago contended the disease fell upon any part or organ of the body, &c. As this is hardly accurate, perhaps I may be allowed to correct the error.

Dr. Crago mentioned that in Berlin they have already divided influenza into three classes, but against this nomenclature I had already advanced the hypothesis that the body becoming infected the brunt of effect may fall upon almost any organ, and my paper I maintain shows this result.

Indeed, I thought I very fully explained, at the Society, that this was my interpretation of the PROMINENCE of different symptoms in different individuals.

I am not aware that any other writer has adduced this theory, and I therefore laid especial stress upon it when replying to the speakers who mentioned that influenza was likely to be divided into three classes. If such a division obtain, I should like to add on the myalgic, the renal, the gastro-intestinal, the circulatory, &c. varieties, in accordance with the particular organ or system which manifests the greatest derangement. Either these classes are too few or superfluous. In conclusion, I should like to reiterate that my experience of influenza showed that it might be most pronounced in almost any organ, but this characteristic did not warrant the separation of the disease into different sections.

Yours, &c.,

R. HODGSON.

Croydon (Sydney),
August 16th, 1890.

DISCUSSION ON PLEURISY.

(To the Editor of the A.M.G.)

SIR,—In the report of the July meeting of the S. A. Branch on the discussion on Pleurisy and its treatment, it would appear from Dr. Hayward's reply to my remarks that I had been arguing from a single successful case that a certain course should be pursued. This was not my meaning, and by the courtesy of our President I was allowed to explain; these latter remarks not having been published I will ask your leave to give the substance of them.

I objected to Dr. Hayward's statement that "in all cases where pus is known to exist the chest should be opened without delay," as too sweeping in its character. I quoted a case where the single aspiration of an empyema was followed by such complete relief of all symptoms and improvement of physical signs that, although arrangements had been made for resection of ribs, it was resolved to wait for further indications, and fortunately none arose. What should we have gained by doing the major operation at once? To make my meaning clear I quoted another case recently under my care where aspiration revealed pus; in a day or two it began to rapidly reaccumulate and the dyspnoea to return—a free incision was made, drainage tubes inserted, with a complete recovery in time. Here to have postponed the major operation would have been as non-surgical and unscientific as to have at once proceeded with it in the first case. There can be no hard and fast rule in surgery—we must be guided by general laws and principles, but these laws must be qualified by the peculiar features of each individual case; and that an empyema must be so regarded I think the two cases quoted (as well as those cited by other speakers) clearly show.—I am, yours, etc.,

LEONARD W. BICKLE.

Mount Barker, S.A.,
August 19, 1890.

BOOK NOTIC

THE LITERARY RECREATIONS OF LATE

It is appended a ~~third~~ ~~chapter~~

P. S. Sec

THE LIVERPOOL
 Acc. to which is appended
 James Doolittle Esq. F.R.S.
 Service L.R.C.S. and P. Med. (Y. Canting L.
 Edinburgh and London.)
 The Service on the front
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Service L.R.C. and
Edinburgh and London.)
We compare the Service on the basis
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PRIVATE HOSPITALS IN VICTORIA.

REGULATIONS for the registration and management of private hospitals under the Health Act were passed at recent meeting of the Executive Council. The regulations provide that every keeper or conductor of a private hospital is to apply for registration to the Board of Public Health if he is a medical practitioner, and to the local Council if he is not. The applicant must give particulars as to the kind of cases to be taken in to the private hospital, the accommodation to be provided, the names of the medical attendants, and the maximum number of patients that it is proposed to accommodate. The Board or the Council, as the case may be, will then inspect the building and the arrangements, and register the hospital with or without conditions. If the local Council refuses to register the premises the applicant can appeal to the Board. Private hospitals are to be registered yearly, and no new institutions are to be opened until approved of by the Board. In every such hospital a case-book is to be kept, in which full particulars are to be given in regard to every patient admitted, the nature of the disease and operations performed, and the results of the operations. Particulars of any birth and of any death are also to be entered in the book; in the latter case, the name of the medical attendant and nurse is also to be given. Every death or still birth is to be at once reported to the local Council and the Board. Periodical inspections are to be made by the officers of the Board or the Council, and the registration of any private hospital may be cancelled by the Board if it considers, on inquiry, that the management is unsatisfactory, or the premises are unsuitable, or if the orders in regard to improvements have not been carried out. A full register of each hospital is to be kept by the Council and the Board, giving full particulars as to the number of patients to be admitted in each room, and as to the ventilation, and any conditions imposed by the Board. These regulations are the outcome of the belief that malpractice has been carried on in Melbourne to a greater or less extent.

L. BRUCK, Medical Bookseller, Sydney,

Has in Stock a full supply of the following recent publications for sale:—

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- MARTINDALE & WESTCOTT'S EXTRA PHARMACOPEIA, 6th ed., 1890, 7s. 6d.
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- HIGGLOW'S GYNAECOLOGICAL ELECTRO-THERAPEUTICS, 1889, 8s. 6d.
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Postage extra, at the rate of 1s. 6d. to the £ of order.

THE MONTH.

NEW SOUTH WALES.

IN the Legislative Council on August 7, the Medical Bill introduced by the Hon. Dr. Bowker, was on the motion of the Hon. Dr. Tarrant referred to a Select Committee.

A LEPROSY Bill, legalizing the detention of persons afflicted with leprosy will shortly be introduced by the Government.

A CASE of leprosy has lately been discovered in the Richmond River district in the person of a European resident, a young man aged 28, a native of the colony; he was sent to Sydney and removed to the lepers' quarters at the Coast Hospital, as also another European patient, a boy of 14, who for some time past attended the Balmain public school.

PROFESSOR Dr. Anderson Stuart, of the Sydney University, left by the P. and O. s.s. "Britannia," on a visit to Scotland. Prior to his departure a complimentary dinner was given to him at the Sydney Catering Company's Rooms, Sydney; the chair was occupied by Sir Alfred Stephen, and amongst those present were Sir John Hay, Mr. M'Millan (Colonial Treasurer), Dr. MacLaurin, Dr. Renwick, Dr. Mackellar, and others.

PROFESSOR Dr. Wilson, the Challis Professor of Anatomy at the Sydney University, has been appointed Acting-dean of the Faculty of Medicine during the absence from the colony of Professor Stuart.

DR. MACLAURIN, Professor Dr. Wilson and Dr. J. C. Cox have offered to defray the cost of busts to adorn the corridors of the new medical school at the Sydney University.

THE Carrington Centennial Hospital, near Camden, was formerly opened for the reception of patients by Lady Carrington on August 20.

THE foundation-stone of the new Nurses' Home at the Prince Alfred Hospital, Sydney, was recently laid by Lady Carrington.

THE Tirrani Public school in the Richmond river district has been closed by direction of the Minister for Public Instruction. This step has been rendered necessary in consequence of reports that some children are developing symptoms of leprosy, Tirrani being the locality whence the man was taken whose case when sent to Sydney was pronounced to be leprosy. It is the intention of the Health Department to send Dr. Ashburton Thompson to report upon these cases.

DR. W. G. ARMSTRONG, of Merriwa, has been appointed Honorary Captain of the local Reserve Rifle Company.

DR. J. J. Y. BABER, a new arrival, has succeeded to the practice of Dr. T. Frangley, at Goulburn.

DR. N. P. ELLIOTT, formerly of Brunswick (Melbourne), has settled at Hurstville, a suburb of Sydney.

DR. B. KORFF has removed from Urana to Broken Hill.

DR. J. W. MARTIN, late of Albert Park (South Melbourne), and formerly of the Creswick Hospital, has removed to Urana, 381 miles S.W. of Sydney.

DR. A. F. PARKER, late of Lismore, has commenced practice at Randwick, a suburb of Sydney.

DR. C. R. FIGG, late of Hurstville, has commenced practice at Pitt-street, Redfern (Sydney).

DR. R. K. ROTH, of College-street, Hyde Park, has been appointed Surgeon to the Public Schools Cadet Force, with the relative rank of Captain.

DR. G. A. VAN SOMEREN, late of Townsville (Qu.), has succeeded to the practice of the late Dr. Proudfoot, at Orange.

DR. C. H. J. SOUTER, has removed from Hillston to Orange.

DR. R. T. WESTBROOK, late of Numurkah (Vic.), has settled at Narandera, 348 miles S.W. of Sydney.

NEW ZEALAND.

THE report by Dr. Ginders, of Rotorua, on leprosy among the Maories at Taupo and Rotorua has been published. His conclusions are that the disease known to the Taupo and East Coast tribes as "ngerengere," to the Ngapuhi and Northern tribes as "puhipuhi," and to the Wanganui and Western tribes as "tawhenua," is one and the same disease, and that true leprosy. No one, the report adds, who has seen leprosy could possibly mistake the symptoms presented by two of the cases inspected. The general consensus of opinion amongst the Maories, that the disease first appeared on the North island at Hauraki, sometime during the latter half of the 17th century, Dr. Ginders thinks may be regarded as true. It was probably introduced by the marooning of a leper from a ship, possibly a whaler, near Hauraki. The term "wero ngerengere" is the term applied to the art of communicating the disease by puncture or inoculation. In all probability the worst cases have arisen from inoculation, either accidental or premeditated experience showing that it is not infectious or contagious in the ordinary sense. Dr. Ginders concludes by saying that complete segregation of those affected would probably stamp out the disease in a few years.

DR. J. F. CAROLAN has removed from Warkworth to Bombay, 29 miles S. of Auckland.

QUEENSLAND.

DR. JOSEPH H. LITTLE, of Brisbane, has for many years enjoyed the esteem and confidence of his professional brethren, and the deepest sympathy is being extended to him in the loss he has sustained through the death of his wife, which took place on August 19th.

DR. W. R. BACOT, of the Geraldton Hospital, and Dr. F. J. Elliot, of the Townsville Hospital, have exchanged positions.

DR. AENEAS J. McDONNELL, late Surgeon of the Toowoomba Hospital, has returned from his trip to China and entered into partnership with Dr. Sheaf, of Toowoomba; Dr. McDonnell has also been appointed an Honorary Surgeon of the local hospital.

DR. W. B. NISBET has been appointed Official Visitor to the Reception House at Townsville, in the room of G. A. Van Someren, M.B., resigned.

DR. F. PAIN has removed from Allora to Warwick.

SOUTH AUSTRALIA.

DR. H. E. COMYN, of Gladstone, had a narrow escape from drowning in the Rocky River on August 27. He attempted to cross the river with a pair of horses, both of which were drowned, but Dr. Comyn managed to climb into a tree, from which he was rescued by a trooper after two hours.

DR. C. L. STRANGMAN has commenced practice at Port Adelaide; Dr. A. J. Davies, at Prospect (Adelaide); Dr. J. Maher, at Gawler; and Dr. V. Fogglioli, at Renmark.

TASMANIA.

AT a meeting of the newly formed Tasmanian Branch of the British Medical Association held at Hobart, on Thursday, 28th July, Dr. Agnew was elected President; Drs. Harvey, Giblin, Butler, Gray, Barnard and Hardy, Members of the Council; Dr. Payne, Hon. Treasurer; and Dr. Wolfhagen, Hon. Secretary.

VICTORIA.

MR. AKEHURST and Drs. Shields and M'Crea have been appointed a board to investigate certain allegations made by Dr. Fishbourne to the effect that patients in the Yarra Bend Asylum Hospital were neglected. The board has been appointed at the special request of the medical officers of the asylum, who are anxious that they should be relieved of undeserved stigma.

A SERIOUS outbreak of diphtheria has occurred at Albert Park, Melbourne; four deaths have occurred in one family.

FOR the first six months of the present year the deaths from diphtheria in Melbourne and suburbs numbered 261, as against 137 for the same period last year, and 68 for the first six months of 1888. During the week ending 16th August, there were 48 cases for the whole colony and 14 deaths, of which six deaths occurred in the metropolitan district.

THE ordinary monthly meeting of the Medical Society of Victoria was held in the hall of the society, East Melbourne, on September 3, under the presidency of Dr. Jackson. On the motion of the president, Dr. William Barker, of South Melbourne, was heartily congratulated on the attainment of his 50th year of medical practice in Victoria. Dr. J. P. Ryan read a paper on the late epidemic of influenza, which elicited a prolonged discussion. Dr. Moore exhibited a case in which the tongue had been removed for malignant disease, and Dr. Barrett exhibited a case in which trephining had been performed for middle ear disease. Drs. Duncan (Kyneton), Cowan, and Moore showed some pathological exhibits, and the meeting terminated.

MR. JAMES JEKELL ARMSTRONG, L.R.C.P., Irel. 1851, a colonist of 33 years' standing, died at Taradale, on the 1st September, at the age of 62.

DR. L. DRUITT, late of Wagga (N.S.W.), has commenced practice at St. Arnaud.

DR. G. BILLING HALFORD has succeeded to the practice of Dr. W. Wood, at Malvern, near Melbourne.

DR. J. E. NEILD, of Melbourne, late dramatic critic of the *Australasian*, was presented on August 18th with an illuminated address and a cheque for £761 as a token of respect from the theatrical and musical professions and private friends. The presentation was made by Mr. George Coppin on the stage of the Princess Theatre in Melbourne.

DR. G. H. SKINNER has settled at Broadford, 47 miles north-east of Melbourne.

Massage. — MR. ERNEST T. KING (pupil of Dr. Roth) undertakes male massage under the supervision of medical men. Address—239 Victoria Street, Darlinghurst, Sydney.

HOUSEKEEPER TO MEDICAL MAN.—English Lady of extensive experience in the management of large establishments is desirous of obtaining position as above. Highest references. Address: E. B., care of Mr. Bruck, A.M.G. Office.

PROCEEDINGS OF COLONIAL MEDICAL
BOARDS.

The following gentlemen, having presented their diplomas, have been duly registered as legally qualified Medical Practitioners by the respective Boards:—

NEW SOUTH WALES.

Davies, Samuel Hickman, L.R.C.P. Edin. 1890; L.F.P.S. Glasg. 1890; L.R.C.S. Edin. 1890.
Dixon, Charles, M.R.C.S. Eng. 1883.
Kearney, James, L.L. Mid. K.Q.C.P. Irel. 1889; L.R.C.S. Irel. 1888.
Kelly, William Henry, M.B. Univ. Dub. 1879.
Neill Channing, M.D. et M. Ch. Q.U. Irel. 1876; L.R.C.S. Edin. 1881.
Praeger, Lionel Francis, M.B. et Ch. B. Univ. Melb. 1889.
Struthers, James, M.B. et M.S. Univ. Aberd. 1883; M.D. Univ. Aberd. 1888.
Thompson, Percy Weekes, M.B. Univ. Toronto, 1888; L.R.C.P.S. Edin. 1888.
Westbrook, Richard Talbot, L.A.H. Dub. 1887; M.R.C.S. Eng. 1887.

NEW ZEALAND.

Ward, John, M.D. St. And. 1863; M.R.C.S. Eng. 1863.
Kendall, Henry William Martindale, M.R.C.S. Eng.; L.S.A. Lond.

QUEENSLAND.

Bacot, William Rickward, M.R.C.S. Eng. 1887.
Hirschfeld, Eugene, M.D., State's Exam.

SOUTH AUSTRALIA.

Davies, Alfred Joseph, L.R.C.P. et R.C.S. L.M. Edin.; L.F.P.S. L.M. Glasg.
Maher, James, L. et L. Mid. R.C.P. et R.C.S. Edin.; L.F.P.S. Glasg.
Morris, Edward Walter, M.R.C.S. Eng.; L.R.C.P. Lond.; L.S.A. Lond.
Poggioli, Vitaliano, M.D. Ch. M. Bologna.
Strangman, Cecil Lucius, L. et L. Mid. R.C.P. et R.C.S. Edin.; L. et L. Mid. F.P.S. Glasg.

VICTORIA.

Gibbs, Richard Horace, L. et L. Mid. R.C.P. et R.C.S. Edin. 1890; L.F.P.S. Glasg. 1890.
Druitt, Lionel, M.D. Edin. 1882; M.R.C.S. Eng. 1875; L.R.C.P. Lond. 1877.

Additional Qualifications Registered:—

Bracewell, Walter H., Ch. B. Melb. 1890.
Cherry, Thomas, Ch. B. Melb. 1890.
Jermyn, Walter H., Ch. B. Melb. 1890.
Rigby, George O., Ch. B. Melb. 1890.

MEDICAL APPOINTMENTS.

Carruthers, Charles Ulrick, L.K.Q.C.P. Irel., L.R.C.S. Irel., to be Visiting Surgeon to the N.S.S. "Vernon," Port Jackson.
Clubbe, Charles Perry Barlee, L.R.C.P. Lond., M.R.C.S. Eng., to be Public Vaccinator for the district of Randwick, N. S. W.
Cookson, Reginald George, L.R.C.P. Lond., to be Officer of Health for the district of Zeehan, Tas.
Elliot, Frederick John, M.R.C.S. Eng., to be Government Medical Officer at Geraldton, Qu.
Gormley, John William, L.R.C.S.I., L.K.Q.C.P. Irel., to be Officer of Health for the districts of Green Ponds and Bothwell, Tas., vice Dr. H. H. Meyers, resigned.
MacRoberts, William Kirkpatrick, M.B. et Ch.M. Roy. Univ. Irel. L.K.Q.C.P. Irel., to be Government Medical Officer and Vaccinator for the district of Gosford and Brisbane Water, N. S. W.
Martin, John Wilson, M.B. et Ch. M. Ed., L.R.C.P. et R.C.S. Ed., L.F.P.S. Glasg., to be Government Medical Officer and Vaccinator for the district of Urana, vice Dr. B. Korff, resigned.
Miller, Hubert Lindsay, M.D. et Ch. D. Brux., L.R.C.S. et R.C.P. Ed., to be Public Vaccinator at Warrnambool, Vic.
Nickson, Wilfred John Robert, M.B. et Ch.B. Dubl., to be a Surgeon in the New South Wales Naval Reserve, vice Dr. Baker, resigned.
Rygate, Charles Daniel Hartley, M.R.C.S. Eng., L.R.C.P. Lond., to be Government Medical Officer and Vaccinator for the district of Warren, N. S. W.
Skinner, George Henry, M.R.C.S. Eng., to be Public Vaccinator at Broadford, Vic.

BIRTHS, MARRIAGES, AND DEATHS.

. The charge for inserting announcements of Births, Marriages, and Deaths is 2s. 6d., which should be forwarded in stamps with the announcement.

BIRTHS.

COLE.—On the 28th August, at Gayndah, Qu., the wife of Dr. Arthur Cole of a son.
KEYES.—At Nathalia, Vic., the wife of Dr. J. J. Keyes, of a daughter.
LENDON.—On the 31st July, at Adelaide, the wife of Alfred A. Lendon, M.D., of a daughter.
PHILIP.—August 8, at Surry Hills, Sydney, the wife of Dr. Alexander Philip, of a son.
TAYLOR.—On the 12th August, at Melbourne, the wife of Dr. Inglis Taylor, of a son.
WILKINSON.—On the 18th August, at Bright, Vic., the wife of Dr. J. F. Wilkinson, of a daughter.
YOUNG.—At Maclean, Clarence River, the wife of R. W. Young, M.R.C.S. Eng., of a son.

MARRIAGES.

CLAYTON—PARKER.—On the 16th July, at Christ Church, Brunswick, Melbourne, Dr. W. M. Clayton, Hawthorn, to Madeline, widow of the late A. E. Parker, Launceston, Tasmania.
FETHERSTONHAUGH—GAYER.—On the 30th July, at St. Matthew's Church, Prahran, Melbourne, Dr. Robert T. Fetherstonhaugh, of Kyneton, to Edith Maud, eldest daughter of Robert Gayer, Windsor.
HAYES—PARKES.—On the 29th August, at Holy Trinity Church, Balclutha, Melbourne, Horace Frederick Hayes, M.B., M.R.C.S. Eng., Caulfield, to Nancie Penrose, fourth daughter of the late B. S. Parkes, Melbourne.
HOGGAN—HINDLEY.—On 25th June, at St. Andrew's, Lutwyche, Brisbane, Bertram Brooke Hoggan, Acting Resident Medical Officer, Brisbane Hospital, to Eileen, eldest daughter of the late Thomas Hindley, late Captain Royal Artillery.
WILSON—SMITH.—September 4, at Chalmers Presbyterian Church, Adelaide, S.A., J. T. Wilson, Challis Professor of Anatomy, University of Sydney, to Jane Elizabeth, youngest daughter of the late Rev. Walter Smith, Gretna, Scotland.
WRIGHT—BARBER.—On the 19th August, at St. John's Church, Darlinghurst, Sydney, H. G. A. Wright, M.R.C.S. Eng., to Augusta Lucy, third daughter of the late Louis Barber, of Sydney.

DEATHS.

LITTLE.—On the 19th August, at Petrie's Bight, Brisbane, Agnes Elizabeth, the wife of J. H. Little, M.B., aged 31 years.
WAUGH.—On the 8th August, suddenly, at Brisbane, Magdalen, third daughter of John Neill Waugh, M.D.

PUBLICATIONS RECEIVED.

Pulmonary Consumption in the Light of Modern Research. By Stephen Smith Burt, M.D. (from the *New York Medical Record*, April 12, 1890.)

Masso Therapeutics, or Massage as a Mode of Treatment. By Wm. Murrell, M.D., F.R.C.P. 5th Ed. London: H. K. Lewis, 1890.

Another hitherto Undescribed Disease of the Ovaries. By Mary A. Dixon Jones, M.D. (Reprinted from *N. Y. Medical Journal*, May 10 and 17, 1890.)

Bacteria and their Relation to Disease. By Isaiah de Zouche, M.D. (address as President of the Otago Institute.)

Annual of the Universal Medical Sciences. A yearly report of the progress of the sanitary sciences throughout the world. Edited by Charles E. Sajous, M.D. 5 vols. 1890. F. A. Davis, Philadelphia, &c.

REPORTED MORTALITY FOR THE MONTH OF JULY, 1890.

Cities and Districts.	Population.	Births Registered.	Deaths Registered.	Deaths under Five Years.	Number of Deaths from									
					Measles.	Scarlet Fever.	Croup and Diphtheria.	Whooping Cough.	Typhoid Fever.	Dysentery and Diarrhoea.	Phthisis.	Heart Disease.	Cancer.	Child-bearing.
N. S. WALES.														
Sydney	128,880	284	188	66	...	...	5	...	2	1	20	17	9	...
Suburbs	252,850	887	289	120	..	1	15	...	1	2	36	16	8	4
NEW ZEALAND.														
Auckland	33,307	66	29	3	...	...	1	...	1	...	5	4	2	...
Christchurch...	17,116	35	12	8	...	...	...	1	...	...	...	1	...	...
Dunedin	24,168	57	25	3	...	...	...	...	...	1	3	2	3	1
Wellington	31,028	80	29	7	...	...	...	...	...	2	1	2	1	...
QUEENSLAND.														
Brisbane	51,689	231	110	37	}	2	5	2	1	12	16	12	2	2
Suburbs	21,960	154	41	25										
SOUTH AUSTRALIA														
Adelaide	319,138	...	...	...	...	...	...	...	...	...	...	...	...	...
Adelaide	44,581	...	...	...	...	...	...	...	...	...	...	...	...	...
TASMANIA.														
Hobart	35,892	112	57	9	...	...	1	...	5	...	1	6	2	1
Launceston	22,089	68	28	4	...	...	...	...	1	...	2	4	3	...
Country Districts.....	94,477	269	84	...	...	...	...	1	1	2	...	...	...	..
VICTORIA.														
Melbourne	75,400	139	1,482	} 271	...	4	54	...	12	10	80	65	16	5
Suburbs	362,385	72	646											

METEOROLOGICAL OBSERVATIONS FOR JULY, 1890.

STATIONS.	THERMOMETER.					Mean Height of Barometer.	RAIN.		Mean Humidity.	Prevailing Wind.
	Maximum Sun.	Maximum Shade.	Mean Shade.	Minimum Shade.	Depth.		Days.			
							Inches			
Adelaide—Lat. 34° 55' 33" S. ; Long. 138° 36' E.....	...	...	...	...	...	...	...	...	...	...
Auckland—Lat. 36° 50' 1" S. ; Long. 174° 49' 2" E.....	115	64.0	53.9	42	...	...	5.190	28	78	...
Brisbane—Lat. 27° 28' 3" S. ; Long. 153° 16' 15" E.	124.7	75.1	56.5	36.2	30.070	...	0.431	6	64	s.
Christchurch—Lat. 43° 32' 16" S. ; Long. 172° 38' 59" E.....	102.2	56.2	41.9	27.8	...	...	3.377	22	81	...
Dunedin—Lat. 45° 52' 11" S. ; Long. 170° 31' 11" E.....	90	50	40.3	32	...	...	5.370	17	84	...
Hobart—Lat. 42° 53' 32" S. ; Long. 147° 22' 20" E.....	...	56.3	44.8	31.8	...	...	2.67	12	86	...
Launceston—Lat. 41° 30' S. ; Long. 147° 14' E.....	...	63.5	45.5	24.5	...	...	4.27	8	85	...
Melbourne—Lat. 37° 49' 54" S. ; Long. 144° 58' 42" E.....	...	62.4	47	29	29.993	...	2.71	13	...	...
Sydney—Lat. 33° 51' 41" S. ; Long. 151° 11' 49" E.	63.5	51.3	35.9	30.064	...	9.01	18	82	w.
Wellington—Lat. 41° 16' 25" S. ; Long. 174° 47' 25" E.....	101	58	47.6	33	8.950	25	83	...

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